MEDICARE AND MEDICAID FRAUDS

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HEARING

BEFORE THE

SUBCOMMITTEE ON LONG-TERM CARE

OF THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

PART 5—WASHINGTON, D.C.

AUGUST 30, 1976

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Printed for the use of the Special Committee on Aging

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Medicare and Medicaid Frauds:
Part 1. Washington, D.C., September 26, 1975.
Part 2. Washington, D.C., November 13, 1975.
Part 3. Washington, D.C., December 5, 1975.
Part 4. Washington, D.C., February 16, 1976.
Part 5. Washington, D.C., August 30, 1976.
Part 6. Washington, D.C., August 31, 1976.
Part 7. Washington, D.C., November 17, 1976.
Part 8. Washington, D.C., March 8, 1977.
Part 9. Washington, D.C., March 9, 1977.
(Additional hearings anticipated but not scheduled at time of this printing.)

94th Congress / 2nd Session / 1976

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MEDICARE AND MEDICAID FRAUDS

MONDAY, AUGUST 30, 1976

U.S. SENATE,
SUBCOMMITTEE ON LONG-TERM CARE
OF THE SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The subcommittee met, pursuant to notice, at 9:40 a.m., in room 318, Russell Senate Office Building, Hon. Frank E. Moss (chairman) presiding.

Present: Senators Moss, Clark, Nunn, Percy, Beall, and Domenici.

Also present: William E. Oriol, staff director; David A. Affeldt, chief counsel; Val J. Halamandaris, associate counsel; John Guy Miller, minority staff director; Patricia G. Oriol, chief clerk; Alison Case, assistant chief clerk; and Eugene R. Cummings, printing assistant.

OPENING STATEMENT BY SENATOR FRANK E. MOSS, CHAIRMAN

Senator Moss. The hearing will come to order.

This of course is a very busy time in the Senate and we want to get started promptly because we have much ground to cover.

Senator Percy, Senator Domenici, Senator Beall, and I are happy to welcome you here this morning to this hearing which is conducted by the Subcommittee on Long-Term Care of the Senate Special Committee on Aging.

We are expecting to be joined by other Senators. Particularly, Senator Talmadge had planned to be with us this morning; however, he is on the conference committee on the tax bill that went into session at 9:30 and obviously had to be there because of the nature of that conference.

Senator Nunn, chairman of the Oversight Subcommittee of the Senate Government Operations Committee, is expected to join us and we hope that he will be able to come in shortly.

Senator Church and Senator Williams, both members of the Special Committee on Aging, have submitted statements.[1] They will not be able to be with us this morning. Senator Church is the chairman of the full committee. We have their statements which will be placed in the record.

Also, Senator Muskie is chairman of the Budget Committee with whom we have cooperated in some of these hearings.

I mention all of this because they all have a great interest in the matter that is before us. But because of the multiple duties that Sen-

[1] See pp. 523 and 524.

ators have, it was not possible for them to be here at the opening this morning. We do value the cooperation of these Senators and of the committee staffs that serve Senator Talmadge's Subcommittee on Health of the Commitee on Finance and Senator Nunn's Committee on Government Operations.

Senator Talmadge has been kind enough to incorporate several of our recommendations into his bill—S. 3205—the Medicare and Medicaid Reform Act of 1976.

27 Hearings on Fraud and Abuse Since 1969

The subject of today's hearing is fraud and abuse among practitioners in the medicaid program. Before discussing this topic a few words of background are in order.

From July 1969 until the present we have conducted some 27 hearings dealing with fraud and abuse in the nursing home field. We have drafted the bulk of a 12-volume report with our recommendations which we have presented to the Congress.

Last September joint hearings were held by this subcommittee and the Subcommittee on Health of the Elderly, chaired by Senator Edmund S. Muskie. In this exploratory hearing we took a quick look at fraud and abuse by other medicare or medicaid practitioners associated in one way or another with long-term care. In these hearings we learned about the excesses of factoring companies, the problems associated with some hospitals that cater to welfare patients and possible kickbacks among clinical laboratories.

In October, hearings were held dealing with possible abuse of the medicaid program by for-profit home health agencies.

In December, hearings were held on conditions in Kane Hospital, a 2,200-bed facility in Allegheny County, Pa., which disclosed widespread patient abuse and mismanagement of public funds.

In September and again in March we held hearings on the growing trend to dump patients from State mental hospitals into boarding homes. We examined the poor care in boarding homes and the associated ripoff of the supplemental security income program.

Last February we released our report dealing with fraud and abuse among clinical laboratories. In that investigation, conducted jointly with Chicago's Better Government Association, we learned that perhaps $1 out of every $5 paid for laboratory services is ripped of.

Since that time we have evaluated the performance of medicare's program integrity unit in a forthcoming report dealing with practitioner abuse of the medicare program. We have completed followup investigations into clinical laboratory, home health, pharmacy, and nursing home abuses. Some of these inquiries have been turned over to the General Accounting Office or other Federal and State authorities because we simply do not have the manpower to follow through properly on each one of these efforts.

In the near future we expect four reports from the General Accounting Office dealing with the handling of patients' funds in nursing homes, the required supplementation of medicaid money by families placing patients in nursing homes, a financial audit of Kane Hospital, and a closer look at the practices of factoring firms.

In short, today's report dealing with medicaid practitioners follows extensive investigations of the various aspects of the medicaid pro-

gram. Invariably, whatever part of the medicaid program we studied, we found substantial problems, mismanagement, waste, and fraud. Accordingly, it is important for everyone to understand that the judgments in today's report are based on the totality of our experience.

Medicaid Mills—Small For-Profit Welfare Clinics

In an effort to examine fraud and abuse among practitioners in the medicaid program we started with a list of doctors making more than $100,000 a year from the program. We soon learned that most of these practitioners worked out of medicaid mills—small for-profit welfare clinics which checker the ghettos of our major cities. We decided to examine such facilities a little closer. In the course of our clinical laboratory investigation we learned a great deal about their operations. In order to get a still closer look we examined the problem from three perspectives: patient, provider, and government.

We learned the government's point of view by interviewing local, State, and Federal officials and reading reports detailing program deficiencies. We learned the provider's point of view by interviewing doctors, by posing as businessmen pretending to buy medicaid mills. We learned about the quality of care in medicaid mills by posing as patients, making about 200 visits to clinics in 4 States.

When I heard from the staff about the blatant overutilization, unnecessary testing, the ping-ponging and referring patients to particular pharmacies, I decided to go to New York to see things for myself.

I put on the oldest clothes I could find. The U.S. attorney helped me obtain a valid medicaid card in my name. On June 7, accompanied by Pat Oriol, chief clerk of the Senate Committee on Aging, I entered the East Harlem Medical Center posing as a medicaid patient with a cold.

This facility was selected because three Senate staff members posing as patients had entered the facility and had been referred from practitioner to practitioner and given a full battery of unnecessary tests.

The physician gave me a brief cursory examination, took a quick medical history asking if I had high blood pressure, diabetes, or anything of the sort. Even though there was nothing wrong with me, he told me that I had a red throat and ordered blood and urine tests and X-rays. The doctor asked me if anything else troubled me and I said once in a while my neck is a little stiff. The doctor decided I needed to see Mr. Cohen, the chiropractor.

As there was no intercom in the facility, the nurse shouted up the stairs to warn the chiropractor I was coming. The doctor asked me some questions, twisted my neck and stated, "There, doesn't that feel better?" He stressed that the relief was only temporary and that he would have to get at the underlying causes for me to realize any permanent cure. He invited me back for treatment the next day and I was given a battery of X-rays. As I left, I was told to be sure to return the next day for more work and reminded to fill my prescriptions at the pharmacy next door.

I also visited the clinic at 164th Street and Morris Avenue in the Bronx. The shoppers who had entered this facility were greeted with

a 30-needle allergy test before they ever saw a doctor. Again the pattern of treatment was the same: a brief examination, extensive blood and lab work, and a number of referrals. I was given a number of tests and scheduled to come back for still more, and for possible referral to other practitioners. I was given a handful of prescriptions and told to fill them at the adjacent pharmacy. Directing a patient to a particular pharmacy, I might add, is a violation of State and Federal regulations.

Adiicts' Haven

The third facility I visited was at 209 East 14th Street in New York's Lower East Side. The staff had been turned away on six previous attempts to seek treatment. The clinic was a haven for addicts. The staff was successful in taking movie film of some of the drug sales which took place on the street in front of the clinic.

I did not receive treatment in this facility but I did enter the adjacent pharmacy. The pharmacy was in the basement of what was really a small cellar partitioned in the middle by bulletproof glass which separated the pharmacist from the customers. A number of apparent addicts were milling about. Behind the glass a pharmacist stood filling prescriptions at random. Two months after my visit, the city health department closed the center, saying that the doctors who operated in this medicaid mill were essentially using their medical licenses to act as drug pushers.

From this experience I have some impressions of what it is like to be a welfare patient. They include:

If you are a medicaid patient, you can expect to be treated in a clinic located in a dilapidated part of the city.

The outside of these clinics, or medicaid mills, are garish. Most offer a brick facade. They may be brightly painted, with awnings, banners, and pennants attracting the eye. The front window lists an impressive array of services—everything from a psychiatrist to a podiatrist.

Inside the mill will be cramped and sparsely furnished. It will be dirty. Cleanliness is not prized in medicaid mills; it costs too much money. The floors look like they haven't been swept in a month and the restrooms are abominable.

As you enter a mill you will be greeted by a receptionist or someone who looks like a nurse. This is important because you never know for sure. This receptionist will ask for your medicaid card. She will xerox it a number of times. You may be asked who you want to see or what your medical problem is or you may not.

Now you wait for an hour, sometimes two. While you wait the receptionist or someone else may suggest that you should see Dr. So-and-so, the chiropractor, or Dr. XYZ, the podiatrist.

When you do get to see a practitioner, your visit will be brief—usually from 3 to 5 minutes—and the examinating room will be tiny.

You will be given a general examination no matter how specific your complaint. If blood pressure is taken or a stethoscope is used, the odds are it will be done through your clothing. It is likely that you will not be touched. Medicaid doctors don't like touching their patients.

At some point the doctor will take blood. The taking of blood confirms that treatment has been rendered to the patient but, perhaps just as important, samples presented to clinical laboratories will generate a return of $15 each from the laboratory.

In addition, you are going to be asked for a urine sample; you will be given a number of X-rays and perhaps a shot or two. You can count on receiving several prescriptions. In most cases you will be directed to a particular pharmacy to have your prescriptions filled.

If you're not sick, you won't be told you're not sick. If you are sick, the odds are you won't be helped. In the last analysis, the best description is the one given to us by a mill owner who said: "Medicaid isn't medicine, it's business. Curing patients is good medicine but bad business."

"I am Outraged"

I want to tell you that after this firsthand personal experience, I am outraged. I am angry that the money the Congress has appropriated for the care of the aged, the blind, and the disabled is going to line the pockets of a few businessmen and real estate operators. I am angry that 10 years after the enactment of the medicare program we find the resurrection of that abhorrent dual track of medical care which provides one standard of care for the rich or comfortable and another for the poor. I am angry that so much of the taxpayers' hard-earned dollars is lost to fraud and abuse. There are millions of people in my home State and across the Nation who work too hard for their money to be able to stomach the fraud and abuse, which by now must be evident to anyone who subjects the medicaid program to the slightest scrutiny.

I am not talking just about medicaid, mills. I am talking about the fraud and abuse we have discovered in nursing homes. I am talking about the recent disclosures of fraud and abuse in prepaid health plans. I am talking about the ripoffs among some for-profit home health agencies and hospitals that specialize in welfare patients. I am talking about clinical laboratories. I am talking about moving patients from State hospitals to nursing homes and boarding homes to take advantage of medicare and SSI. The day is long since past when we can tolerate the poor care and obvious fraud, waste, and abuse that exists in the medicaid program. It is time for an overhaul. I know that with the assistance of the Senators here today, we can move quickly to enact Senator Talmadge's bill, S. 3205. The enactment of this bill would do much to reduce the festering problems with which we have been grappling for too many years.

I apologize somewhat for the length of that statement but I think it will help to set the stage for what we expect to find in our hearings which we have detailed in this report which is released today on "Fraud and Abuse Among Practitioners Participating in the Medicaid Program."

[The statements of Senator Church and Senator Williams follow:]

STATEMENT BY SENATOR FRANK CHURCH

I wish to join in commending you, Mr. Chairman, and the two members of the Capitol Police force who performed outstanding services while assigned temporarily to the Senate Committee on Aging within recent months.

You are to be applauded, Mr. Chairman, for your tireless efforts to expose fraud and abuse in the medicaid program. It took a great deal of courage to go to New York and see things for yourself.

The two Capitol Hill policemen who participated in the investigation are Privates James A. Roberts, Jr., and Darrell R. McDew. At this point I would like to give my personal thanks to Police Chief James C. Powell and Senate Sergeant-at-Arms F. Nordy Hoffmann for making it possible to assign the two officers for this work. Privates Roberts and McDew visited more clinics than anyone else in the investigation, gave more blood for "tests," and bore up doggedly despite the wide number of illnesses diagnosed for them. I might add that they had received a complete physical and were pronounced physically fit before the shopping began.

As chairman of the Committee on Aging, I take a great deal of pride in the achievements which are being revealed to the American public this morning. I know the end result will be legislation to curb these widespread abuses. I pledge my best efforts in bringing about some improvements in the fiscal integrity of Government health care programs.

STATEMENT BY SENATOR HARRISON A. WILLIAMS, JR.

Mr. Chairman, I am pleased to address this hearing by the Subcommittee on Long-Term Care. The hearings conducted by this committee, chaired by Senator Moss, have been greatly informative. They have provided the Congress with valuable insights into fraud and abuse among nursing homes, clinical laboratories, and other providers in the medicaid program.

I expect today's hearings will serve the same end; that is, providing the Congress with the information it needs with which to legislate.

I am proud that my State of New Jersey has been, over the years, one of the most active in terms of preventing fraud and abuse in the entire Nation. According to HEW statistics, New Jersey is one of the three States with excellent fraud detection programs. I am glad to see that the New Jersey Special Commission on Investigation will testify today, sharing the results of their good work with this subcommittee and with the Nation.

I think now everyone knows my commitment to national health insurance and to expanding medicare and medicaid benefits for the aged, blind, and disabled. I am troubled that hundreds of people may be going without the health care they need. But I am just as troubled by the increasing reports of fraud and abuse in these programs. I am hoping that these hearings will help us to redirect Government money so as to eliminate waste and to provide greater benefits for the needy.

Senator Moss. Now I am very pleased to have with me a number of Senators. The ranking Republican member of the subcommittee is Senator Percy, of Illinois, who has been with us on so many of these hearings and has done valuable service in assembling the data that we now have before us. I would like to recognize Senator Percy.

STATEMENT BY SENATOR CHARLES H. PERCY

Senator PERCY. Senator Moss, we welcome you back from the battlefield. It looks like in the reprocessing you have gone to Brooks Brothers this morning to get back here in good shape. I want to commend you and the members of the staff and certainly the Capitol Police that have cooperated with this subcommittee in learning firsthand how some of these programs are really carried out.

I think we learned as we went through a great many nursing homes that there is a great deal of difference between theory and practice. Too few times legislators legislate in a vacuum and don't actually follow up to see what happens. I would hope that those who feel you can wave a magic wand and create a national health insurance program; tack it onto the social security program; and obtain instant free medical assistance and health care for every man, woman, and child in this country with the same degree of efficiency that we offer health care today, would go out and actually see how some of these programs—which are minuscule compared to those that are actually implemented—are carried out.

We have a long way to go before we are ready to enact a total national universal health insurance plan in this country. There is a long gap between theory and practice, and I think you have helped bridge that gap in showing in these relatively modest programs the kind of abuse that is there. Yet we know that medicare and medicaid programs, as such, were desperately needed and we know that there is no substitute for them for some people. We know that some people in the practice carry them out according to the rules. Many people who are recipients do not abuse it, but the abuse is there and the potential for further abuse is there. I think it is now up to us to do something about it.

Since July 1969 this subcommittee has held 27 hearings on medicare-medicaid fraud and abuse. It appalls me that after 7 years of hearings, repeated investigations, and numerous reports we are still here today listening to testimony which identify and confirm the same types of fraudulent practices that have been plaguing the medicaid program since its enactment in 1966.

I would say that on behalf of all the members of the committee here this morning, all of whom are action-oriented, pragmatic, hard-hitting legislators, that the time for talking and for testifying about medicaid fraud and abuse is just about over; it is time now that we act and actually do something about these abuses.

After an 8-month investigation the subcommittee staff has completed a report entitled "Fraud and Abuse Among Practitioners Participating in the Medicaid Program" which gives firsthand evidence of rampant fraud, abuse, and maladministration in the medicaid program and a pattern of reprehensible exploitation of the sick and poor, not to mention the taxpayer who is paying the bill. The findings of the report indicate that as we talked, investigated, and held hearings, medicaid fraud and abuse actually increased in scale and sophistication.

ONE-THIRD OF FUNDS WASTED

The subcommittee report exposed medicaid mills that operate solely for the purpose of defrauding the medicaid system. The subcommittee staff concludes that as much as one-third, or over $1 billion, of New York's total medicaid and public assistance funds have been wasted.

It is my hope that these hearings will act as the catalyst to finally bring about needed legislative and administrative reform of the medicaid programs so that intended medicaid beneficiaries will receive quality health care at a reasonable cost.

The staff recommends that the fraud and abuse provisions of S. 3205, including establishing the Office of Inspector General in the Department of Health, Education, and Welfare, should be enacted immediately. I would like to point out that last week an amendment to the pending legislation in the Senate offered by Senator Nunn and myself was unanimously adopted. There we stamped out, I hope, abuse in the student loan program where we found $1 billion out of $8 billion in unpaid bills, and programs where there was simply inadequate follow through. I have strongly recommended that an Inspector General be installed for that purpose as well as this present scandal that we have involving administration in the Department of Health, Education, and Welfare.

As an original cosponsor of the Medicare-Medicaid Administrative and Reimbursement Reform Act, I trust that we will act immediately to expedite the enactment of that bill. Certainly we can act. We now know what needs to be done and these hearings, I hope, will put to rest the need for further hearings. The time for action is here.

Thank you.

Senator Moss. Thank you very much, Senator Percy.

As I explained at the beginning, Senator Talmadge had intended to be here this morning, but the conference on the tax bill has precluded this. He sent a very brief statement and asked that it be read into the record and I will do that at this time. This is the statement of Senator Talmadge who is chairman of the Health Subcommittee of the Senate Finance Committee.

[Reading:]

STATEMENT BY SENATOR HERMAN E. TALMADGE OF GEORGIA

At the outset I want to commend Senator Moss and this subcommittee for imaginative and innovative work in detecting and defining fraud and abuse in medicare and medicaid.

I have followed carefully the work of this subcommittee in the investigation and disclosure of what is clearly extensive abusive activity in nursing homes and laboratories. I have been briefed as to the areas which will be addressed at this hearing. What we will hear will shock millions of Americans just as it shocked me.

In a moment I will describe what some of us intend to do about these matters. Before doing so, it is highly appropriate to praise and commend the staff of this subcommittee, acting under the leadership of Senator Moss, for demonstrating to all of us that imagination and personal courage are not lacking in the Federal Government. The staff investigators undertook personal risk to develop the story which

will be unfolded today and tomorrow. In fact, in some instances they spent money out of their own pockets to avoid interruption of the investigation. These investigators are a credit to those who support responsible and efficient government.

Now to specifics. Recently the Committee on Finance which has legislative jurisdiction over medicare and medicaid held 5 days of hearings on my bill, S. 3205, the Medicare and Medicaid Administrative and Reimbursement Reform Act. That proposal, in which I was pleased to be joined by Senators Moss and Nunn, along with other Senators, contains a number of significant provisions designed to more effectively prevent, detect, and punish fraud under the Federal health financing programs. It was my expectation that we would act early in the next session to move the bill through the Congress. However, the situation is urgent.

I, therefore, have taken from S. 3205 the various antifraud sections, adding somewhat to some of them and improving upon others. It is my intention to introduce an antifraud bill by early next week. Senators Moss, Nunn, and others have been consulted during the work on this proposal and will join with me in introducing it. It is my hope that this antifraud measure can be added as an amendment to an appropriate House-passed bill this year.

Quite simply, we believe that we should not wait another 6 months to enact vitally needed antifraud legislation. We intend to do all we can to secure passage of these necessary reforms in this session of the Congress.

Again I want to commend Senator Moss for the fine public service he has rendered with this investigation and for the kind invitation to participate in this hearing with you.

[End of statement.]

Senator Moss. Senator Talmadge will join us tomorrow definitely and if he gets a break in that conference he will come in today.

As I announced earlier, Senator Nunn has joined us this morning. He is chairman of the Oversight Subcommittee of the Senate Government Operations Committee.

Senator Nunn, do you have any opening statement you would like to make?

STATEMENT BY SENATOR SAM NUNN OF GEORGIA

Senator Nunn. Very briefly, Mr. Chairman. I am very pleased to be here this morning. I would ask that my complete statement be put in the record as acting chairman of the Permanent Investigating Subcommittee.

I have had our staff looking into this overall area of medicare and medicaid fraud and abuse. I commend you and your staff for this extraordinary effort. I believe that it will give a major thrust to the Talmadge reform bill which I am cosponsoring. I hope that we will be able to take action on it this year.

Rather than taking more of the committee's time, I do thank you for letting me appear with you. I would ask you to place my full statement in the record.

Senator Moss. Without objection, it will be placed in the record in full.

[The prepared statement by Senator Nunn follows:]

PREPARED STATEMENT BY SENATOR SAM NUNN

I would like to join in commending Senator Moss and this Special Committee on Aging for their extraordinary and continuing oversight investigations into fraud and abuse in the medicare and medicaid programs.

I am acting chairman of the Permanent Subcommittee on Investigations, which is likewise conducting inquiries into fraud and abuse in the health and welfare industries. I know from our current investigations that what will be presented before this committee today and tomorrow are not isolated examples. Indeed, they are part of the actual conditions in the health care services industry.

They are so much a part of the industry that I believe they are major factors behind increasing program costs and the continuing escalation in national health expenditures. But more importantly, fraud and abuse of the health sector does not simply cost money. It can result in injury to and even deaths of patients who are given too many drugs, too many tests, too many surgeries.

The work of Senator Moss and the Special Committee on Aging in the areas of nursing homes, laboratories, and now the medicaid mills points Congress in an obvious direction. We must address the problems of fraud and abuse more specifically and more forcefully. I hope that Senator Talmadge's antifraud bill will clear the Congress this year. I support it and I am pleased to have worked with him on it.

As I said recently to the Senate Finance's Health Subcommittee, if somehow we could legislate that only men and women of good conscience should be involved in receiving and spending Government health and welfare funds, then we would have no need for systems to spot the culprits. But we cannot.

So we must continue to look for schemes and the schemers and respond immediately with legislative reform and encourage regulatory reform. It will require the continuing vigilance of Congress, the kind of vigilance shown by this special committee and its most capable staff to insure that the laws are sufficient to punish the criminals and to assure ourselves that those charged with administering the laws do so effectively.

Senator Moss. We do appreciate your sitting with us this morning and the cooperation that we have had with your committee as well as Senator Talmadge's committee. The interaction among the committees has been extraordinarily good.

I would just like to mention that Senator Percy is the ranking Republican member on the Nunn subcommittee as well as this subcommittee.

The Senator from Maryland, Senator Beall.

STATEMENT BY SENATOR J. GLENN BEALL, JR.

Senator BEALL. Yes, Mr. Chairman. I ask unanimous consent that my full prepared statement be included in the record.

I would like to take this opportunity to congratulate you and the staff of the committee and the investigators who cooperated in gathering the information for today's hearing. You have done a great service in helping to expose the shortcomings and the abuses of the present

system. I would point out also that the subcommittee investigators did an outstanding job, earlier this year, in bringing to light the fraud which has infiltrated many of the clinical laboratories which participate in the medicare and medicaid programs. I would note, Mr. Chairman, that those earlier hearings prompted me to offer an amendment to S. 1737—the Clinical Laboratories Improvement Act—which increased the criminal penalties for fraud and abuse in the delivery of laboratory services. The Senate passed S. 1737 on April 29, and I would hope that the House of Representatives would act on this important matter before the Congress terminates its activities early in October.

As the ranking minority member on the Labor and Public Welfare Committee's Subcommittee on Aging, I am continually interested in the problem of health care delivery to our senior citizens. Mr. Chairman, you and Senator Domenici, as members of the Budget Committee along with me, have been concerned about and wrestled with the problems of setting national priorities within the constraints of a fiscally responsible Federal budget. Medicare and medicaid are large programs which consume billions of State and Federal dollars each year. They are vital programs that provide medical services to the elderly and the poor who might not otherwise have access to medical care.

I think it is essential that the corruption that exists in these programs must not be tolerated because it drains away vitally needed but necessarily limited resources, thus depriving needy members of our society of the health services they need and deserve. In addition, it rips off the hard pressed American taxpayer, it undermines the public's confidence in the ability of Government to deliver services to our people in an efficient and effective manner, and it will tend to undercut public confidence in the medical profession.

As Senator Percy pointed out, we cannot begin to support a national health insurance plan unless we first have the program structured in such a way as to protect the public from the type of corruption and abuse that you and the subcommittee have turned up in this investigation. I would congratulate you on the work that has been done by the subcommittee and I hope that, as a result of these hearings, we can come up with meaningful legislation that will bring solutions to bear on these very important problems.

Senator Moss. Thank you very much. The full statement will be placed in the record.

[The prepared statement by Senator Beall follows:]

Prepared Statement by Senator J. Glenn Beall, Jr.

Mr. Chairman, I am pleased to participate in this morning's hearing which will focus much needed attention on the serious problem of fraud in the medicaid/medicare programs. The Long-Term Care Subcommittee has, through its investigations and hearings, done much to expose the shortcomings and abuses of the present system.

The subcommittee's team of investigators did an outstanding job of bringing to light the fraud which has infiltrated many of the clinical laboratories which participate in the medicare/medicaid programs. I would note, Mr. Chairman, that those earlier hearings prompted me to offer an amendment to S. 1737, the Clinical Laboratories Improvement Act, which increased the criminal penalties for fraud and abuse in the delivery of laboratory services. The Senate passed S. 1737 on

April 29 and I would hope that the House of Representatives would act on this important matter before the 94th Congress adjourns.

As the ranking minority member on the Labor and Public Welfare Committee's Subcommittee on Aging, I have continually sought to improve the quality of life of our Nation's 22 million senior citizens. As members of the Senate Budget Committee, Senator Moss, Senator Domenici, and I have wrestled with the problems of setting national priorities within the constraints of a fiscally responsible Federal budget. Medicare and medicaid are large programs which consume billions of State and Federal dollars each year. They are vital programs that provide medical services to the elderly and the poor who might not otherwise have access to medicare care.

Corruption in these programs must not be tolerated because:

(1) It drains away vitally needed but necessarily limited resources, thus depriving needy members of our society of the health services they need and deserve.

(2) It rips off the hard-pressed American taxpayer.

(3) It undermines the public's confidence in the ability of government to deliver services to our people in an efficient and effective manner.

(4) It will tend to undercut public confidence in the medical profession.

I repeat Mr. Chairman, that we must not tolerate this kind of corruption. We must promptly root out any and all corruption from the medicare/medicaid programs and we must devise procedures and administrative structures that will prevent its reoccurrence. This is a difficult challenge but the Congress and the administration must meet and resolve this program before we can seriously consider massive new programs such as national health insurance.

In closing, I would note that I gave this matter a great deal of thought when I was drafting S. 2702, the long-term care amendments of 1975. That bill, which is pending in the Senate Finance Committee, would replace medicaid as the funding vehicle for a whole range of medical and nonmedical services delivered in institutional and noninstitutional settings for senior citizens. The mechanism contained in my bill that would hopefully prevent fraud and abuse is the community long-term care center. The community long-term care centers would have an elected governing board, of which a majority would be older persons. That local board and its professional staff would evaluate and certify the long-term needs of the individuals who reside in their service area. The funds would flow from the Federal Long-Term Care Trust Fund to the community long-term care centers by way of a State plan. The center would actually purchase or provide the needed services, such as home health services, homemaker services, nutrition services, long-term institutional care services, day care services, foster home services, and community mental health center outpatient services. The center would control the funds and carry on a continuous followup relationship with each individual receiving services under this program.

In drafting S. 2702, it was my hope that the creation of community long-term care centers would enable us to structure a responsive program with adequate safeguards against abuse, fraud, and/or misuse.

Mr. Chairman, I commend you for undertaking this investigation

and I hope that this series of hearings will help Congress and the executive branch to come to grips with this pressing problem.

Senator Moss. I do appreciate the fine work you have done in cooperating with this subcommittee and the staff as we develop these investigations.

The Senator from New Mexico, Senator Domenici.

STATEMENT BY SENATOR PETE V. DOMENICI

Senator Domenici. I will only take a moment if my statement can be made a part of the record. I do want to commend you and the staff, Senator Moss, for an excellent job. I did not personally visit the medicaid mills in New York, only in Chicago. I am delighted that a number of Senators from important committees of our U.S. Senate are actively involved in trying to help with this very serious problem. It is long overdue.

I personally don't know how we are going to solve the problem; it is an incredible new subculture delivery system that has grown up in the medical practice. It is not the average doctor, but rather just a strange new culture that almost ignores everything that we thought was right and needed by way of a delivery system. Whether or not we are going to solve the problem with fraud and abuse statutes, I don't know. I do wholeheartedly support such measures and I will join in trying to expedite their passage.

It is absolutely incredible when you go into a major American city, particularly the slum area, to see what has happened in the years since medicaid. I don't think anyone would have believed that a slum building would now become a storefront, well-advertised delivery system. The most pronounced act in all of them are the green cards. It is as if we are inviting people off the street to come in, promising care. Then when you get in many medicaid mills you find the paraphernalia that advertises what they have there to offer to our poor people is something again. This deception has created a new culture in America's medical delivery system. You would not believe what is imposed on these people.

Now you have yourself participated in that, Mr. Chairman, as have our staff. I assume that thousands of Americans have already experienced it and hundreds of millions of dollars have gone for naught. I have a word of caution or warning. I don't think laws are going to totally solve the nightmare, but I think the medical profession has a grave responsibility. Ninety-nine percent of them are not involved in this. Most of the involved doctors are foreign medical people, as you know, Mr. Chairman.

Somehow or another we need some help in terms of enforcing the standards of excellence that are delivered to most Americans by the medical practitioners. We need their help in seeing that those who deliver medical service to our poor people, basically in our slums, are also held at that standard also. I don't know how we can do that, but that fact is a must. I think this hearing and the others that will follow it must excite this institution, the Senate, but also the medical people. those who are involved in training our doctors, our medical schools. State and local authorities are just going to have to get concerned enough to join in a war of not only stopping it but also in an affirmative approach of finding a better way to do it.

Thank you, Mr. Chairman.

Senator Moss. Thank you, Senator. Your full statement will be inserted in the record.

[The prepared statement by Senator Domenici follows:]

PREPARED STATEMENT BY SENATOR PETE V. DOMENICI

Mr. Chairman and other members of the committee, I am anxious to proceed with the hearings today so I will say only a few words.

It is simply stunning that the abuses outlined by the subcommittee report and those that will be described personally today have been known by law enforcement officials for at least 10 years. Apparently to know is not enough. Apparently it has to take a public forum as this to force the appropriate remedial action.

I hope this hearing will capture the attention of the public, the entire Senate, and those abusing Federal programs such as medicaid and medicare, and be instrumental in ending these crimes. Perhaps now New York and other States will extend the effort necessary to truly sense their needy, rather than turning a program loose with crossed fingers and good intentions. It seems that the larger States with heavily populated cities are most vulnerable to the disgraces outlined in the subcommittee report. It appears that many of the larger States are most lax in their enforcement procedures. Certainly the Federal Government has also been lax in providing adequate enforcement procedures and proper guidelines.

Not only are a few made wealthy at the expense of all taxpayers, but even more abysmal is the fact that the elderly, the poor, and the disabled receive poor health care—if they actually receive it at all. The poor and elderly are the scapegoats in this dilemma and the situation must end, and end now.

The subcommittee report is an alarming commentary of a necessary Federal program gone astray. It is not enough to say these abuses occur only in larger communities. It is not enough to say that only a very small percentage of doctors and other health professionals are involved. Obviously good intentions are not enough when we in Congress or in the State legislatures fail to insure proper safeguards. Too often those we wish to help are forgotten once we enact the "saving" legislation.

Proper enforcement and monitoring procedures are possible as illustrated by the relatively successful operation in Michigan and some other States. The situation in Michigan is not perfect by any means, but it is light years ahead of New York's system.

I am pleased this subcommittee's members and staff have persisted to uncover and document the evidence. The report outlines seemingly unreal situations. How can certain individuals be so successful in abusing social programs directed to the less fortunate in our society? How has it evolved that the elderly and poor are so exploited? How have enforcement procedures become so lax? The facts are there for all to examine. The testimony today and tomorrow will add the personal documentation needed for a final realization that fraud of the worst type, that abuses of the most unreal dimensions exists.

I do not wish to take more of the subcommittee's time now. I wish only to extend my personal commitment in future efforts to eliminate these shocking problems.

Senator Moss. The Senator from Iowa, Senator Clark.

Senator Clark. Mr. Chairman, I have no statement. I would like rather than making an opening statement to ask that there be inserted in the record at this point an article which appears in this week's Newsweek that is out this morning dated September 6, 1976, called "Inside the Medicaid Mills." I am not going to read the whole article, in fact just tantalizingly I am going to read the first sentence.

Senator Moss. I have not seen it yet so my curiosity is aroused.

Senator Clark. You will be interested in it then, Senator. It says, "F. Edward Moss is no ordinary sidewalk derelict." [Laughter]

Senator Moss. Now I believe it.

Senator Clark. I would like that to be inserted in the record at this point if I may, Mr. Chairman.

Senator Moss. Thank you. That will be inserted in the record. Even though I have not had a chance to check the text yet, I will run that risk and place it in the record.

[The article follows:]

Val J. Halamandaris

Undercover man: Senator Moss visits a New York City storefront clinic in disguise

Inside the Medicaid Mills

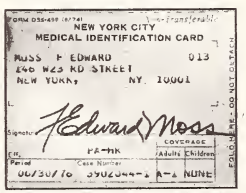
The haggard old-timer, dressed in a grungy denim jacket and Army fatigue pants, shuffled into a storefront clinic in New York's East Harlem one morning in June. He had a cold, the old man complained, as he produced a Medicaid card identifying him as "F. Edward Moss." He waited around for more than an hour before a doctor saw him, took a brief medical history and ordered a blood test, a urine test and a chest X-ray. Next the old man was given a prescription for three drugs and told to have it filled at "the pharmacy next door." When asked if he had any other ailments, the old man mentioned a stiff neck; he was sent to a chiropractor upstairs, who recommended additional X-rays.

F. Edward Moss is no ordinary sidewalk derelict. When not in disguise, he answers to the name Frank E. Moss and works as a U.S. senator from Utah. As a member of the Senate Special Committee on Aging and chairman of the subcommittee on long-term care, Moss took on his unusual undercover assignment for a personal look at Medicaid abuses. "I'm kind of a kick-the-tires man," says the 64-year-old Democrat. "The committee staff was giving me reports that were astounding. I thought I'd like to see for myself." What Moss and his investigators saw—and heard and felt—was a wide assortment of medical flimflams, all to be detailed in a 287-page report that will be made public at hearings in Washington this week.

The Medicaid program, enacted by Congress in 1965 and jointly funded by the Federal, state and local governments, helps to finance health services for the poor. But too often, committee investigators found, Medicaid money has become easy pickings for the unscrupulous. The staff report cites innumerable instances of phony bills for services that were unnecessary or never rendered. One investigator with perfect vision received three prescriptions for eyeglasses; another was X-rayed on a machine that had no film. "Some people are ripping off vast amounts of money by setting up these Medicaid mills and running people through like cattle," Moss told NEWSWEEK'S Henry McGee last week. Of the more than $15 billion that will be spent on Medicaid this year, Moss estimates that fully 10 per cent—$1.5 billion—will be lost through fraud and abuse.

To gain first-hand insight into the malpractices, Moss and six committee staffers posed as Medicaid beneficiaries and made more than 200 visits to approximately 100 clinics in New York, New Jersey, Michigan and California. The investigators usually followed a set procedure: on entering a clinic, they made only a general complaint ("I have a cold"), and they never sought referrals or suggested the need for medical treatment in any other way. Prior to their "shopping tours," the investigators were all in good health, the report said; nevertheless they were diagnosed in the Medicaid mills to be afflicted with everything from bronchitis to a severe infection of the urinary tract. Moss himself returned from his two-day undercover tour of New York City with a painful souvenir: his arm bore ugly purple blotches—a result of clumsily performed blood tests.

Moss's ID card: A doctored name


NEW YORK CITY
MEDICAL IDENTIFICATION CARD
MOSS F EDWARD 013
640 W23 RD STREET
NEW YORK NY 10001
F. Edward Moss
COVERAGE
Adults Children
PA-HK
06/30/76 A-A NONE

'Ping Ponging': Medicaid abuses, the investigators found, came in so many variations as to have a vocabulary of their own. Examples include "Ping Ponging" (referring patients to other doctors within the clinic even when there is no medical need to do so), "upgrading" (billing for additional services not provided), "steering" (sending patients to a particular pharmacy, usually one affiliated with the mill) and "shorting" (delivering fewer pills than prescribed). According to the report, Medicaid costs are further kited through cozy deals between doctors and landlords and between doctors and factors (who usually take over the doctors' accounts receivable and advance immediate payment less a 12-24 per cent service charge).

The report stresses that only a relative handful of doctors have abused the Medicaid program. But some among those few have apparently tapped a bonanza (in 1974, 365 physicians received $100,000 or more from the program). Sheer incompetence often goes hand in hand with greed. At a Los Angeles clinic, one investigator submitted a soap-and-cleanser concoction as a urine sample, which was tested as "normal." A New York facility proved to be little more than a haven for junkies. Committee staffers expressed special concern for the effect of Medicaid mills on the poor. As investigator Catherine Hawes put it: "It's bad enough they're ripping off the government, but they're not even providing minimum levels of medical care—and that's criminal."

To curb future abuses, the report backs legislation to establish an office of Inspector General in the Department of Health, Education and Welfare to police Medicaid (and medicare as well). It also recommends laws banning fee-splitting and shop rentals based on a percentage of income in Medicaid clinics (last week, HEW announced "a flat prohibition against the factoring of Medicaid accounts"). Finally, the report singled out New York City's Medicaid program for a special knock, asserting that Medicaid losses there over the past ten years "probably equal the $1 billion deficit which brought New York City to the brink of [financial] disaster." Had New York taken reasonable steps against Medicaid frauds, the report claims, the city conceivably could have avoided its fiscal crisis.

—DANIEL CHU with HENRY McGEE in Washington

Senator Moss. I certainly appreciate the attention given by all of my colleagues and their statements this morning. They indicate how serious this problem is and really how perplexed we still are as to how we are going to deal with it. We have the Talmadge bill which I am sure is a step in the right direction and I think all of us will want to press for its adoption but we don't know how hopeful we can be that that will resolve all of the problems.

Must Preserve Integrity

As the Senator from Illinois pointed out, as we expand in this field of providing health services for our people we have to find a way that the system can have its integrity preserved and cannot be abused by those who choose to do so and have been successfully doing it with medicare and medicaid as the hearings today I think will indicate.

Now reference has been made by others and I want to echo that reference to the exceptional work done by the staff of the Senate Committee on Aging and particularly those assigned to the subcommittee. They have exerted great imagination and penetration in finding ways to bring our attention to abuses that we will hear of this morning and which are detailed in this report. I have asked a number of those members of the staff and particularly those who went out and did the leg work, the investigation, to come here as a panel and sit and present their report on what they have to tell this subcommittee.

This investigation, as has been pointed out, has been going on for a long period of time and it has required great perseverence to continue to follow up day after day with the most limited of facilities, manpower and financial means that we have at our command and we therefore have entered into agreements with others like the Chicago Better Government Association who did such good work in Chicago.

We also had the good fortune to have two very able officers detailed to work with our committee as investigators who are members of the Capitol Police force and they will be with the panel this morning. I had a chance to be with them for a full day in New York and I can attest to the perception of these men and their real understanding of the problem and their dedication to the job. They did an excellent job.

I will ask Val Halamandaris who is the associate counsel for the Committee on Aging and who was in general charge of all of this investigation, Patricia G. Oriol who is chief clerk of the committee and, as you will see, a lovely lady who did the job of going into these clinics and shopping for services and then reporting on them, and then Darrel McDew and James Roberts, the two police officers to whom I have referred, and Catherine Haws who is an investigator for the committee, to come forward and we will ask for a presentation of their report and of course all of them will be open for questioning by the members.

Mr. Halamandaris. Mr. Chairman, I request that we be sworn.

Senator Moss. All right.

Raise your right hand. Do you and each of you solemnly swear the testimony you are about to give will be the truth, the whole truth, and nothing but the truth, so help you God?

[All answered in the affirmative.]

Senator Moss. You may proceed, Mr. Halamandaris.

STATEMENT OF VAL J. HALAMANDARIS, ASSOCIATE COUNSEL, COMMITTEE ON AGING

Mr. Halamandaris. Thank you, Mr. Chairman.

On behalf of the staff I say thank you from the bottom of my heart for all the kind words that have been said about the work of the subcommittee staff.

I just would like to add this comment: Mention was made of the clinical lab investigation that we conducted in Chicago when you, Mr. Chairman, and others, went to Chicago to see for yourselves. You'll remember we had the invaluable assistance of the Better Government Association. I would like to acknowledge and credit the BGA for their good work.

There is another group that should be mentioned and that is CBS's "60 Minutes" with Mike Wallace. All of the investigations we have done here in 7 years did not have the impact of the single segment on "60 Minutes." I think CBS gave the American public the first graphic evidence of what is going on in the medicaid program.

I would like your permission, Mr. Chairman, to have inserted in the record at this point your statement in the Congressional Record on June 15, 1976, in which you compliment CBS President Richard Salant along with Mike Wallace and Producer Barry Lando for the excellent work they did in conjunction with that program called "The Clinic on Morris Avenue."

Senator Moss. Without objection, that will be in the record at this point.

[The statement follows:]

[From the Congressional Record, June 15, 1976]

"Fraud and Abuse Among Clinical Laboratories"—Special Report of the Committee on Aging—Report No. 94-944

Mr. Moss. Mr. President, on behalf of the Subcommittee on Long-Term Care of the Senate Committee on Aging, I submit a report for publication and use by the Senate. The report is entitled "Fraud and Abuse Among Clinical Laboratories."

This report has been in so much demand that last Thursday the Senate agreed to the printing of 4,500 additional copies of it.

The report details the results of our 5-month investigation of fraud among clinical laboratories in six States, Pennsylvania, Illinois, New York, Michigan, New Jersey, and California. We concluded that $1 out of every $5 paid for medicaid laboratory services is fraudulent. The number of labs who cheat is small but their share of the $213 million in medicaid lab services is large.

The lawbreakers in our report have been brought to justice. In Illinois, 14 laboratories have been suspended. Indictments have been brought against laboratory operators in all six States we studied.

There has also been action on the legislative front. On April 29, the Senate passed S. 1737, the Clinical Laboratories Improvements Act which requires licensure of every lab. In addition, the act makes the offering or receipt of a kickback grounds for the revocation of a laboratory's license. Moreover, amendments were added on the Senate floor which make offering or receiving kickbacks a felony punishable by up to 3 years in jail, a $10,000 fine or both.

I am sure that this prompt action would not have been possible without related investigation by CBS "Sixty Minutes" entitled "The Clinic on Morse Avenue" and aired on February 15. I would like to compliment CBS for this excellent example of investigative reporting. I would compliment in particular, CBS President Richard Salant, Reporter Mike Wallace, and Producer Barry Lando.

The Acting President pro tempore. The report will be received and printed.

Mr. Halamandaris. Mr. Chairman, I would like to take just a few minutes to tell you what we did during the course of this investigation and to have the staff who participated tell you of their findings.

The investigation over the last 8 months consisted of about nine steps. The first thing we did was to examine about 100 reports that have been written concerning problems in the medicaid program. You will find that detailed in part 3 of our report.

Now if I can refer you to page 207, you will find the number of fraud cases reported to the Department of Health, Education, and Welfare by the States. On page 207 you will find that at any quarter during 1975 there were approximately 2,062 cases pending. Then there is a breakdown from the various States as you can see. Some States like California are very active. Massachusetts is very active. Then you look at the totals for the State of New York.

The bottom line is that the State of California, which accounts for some 13 percent of all medicaid moneys, referred 40 percent of the fraud cases to the HEW. On the other hand, the State of New York, which receives 23 percent of all medicaid funds, referred only one-tenth of 1 percent of all the medicaid cases to the Department of Health, Education, and Welfare. That, in a nutshell, gives you a view of the kind of performance New York has given. Historically the State of New York has not been living up to the responsibility, is not in conformance with the Federal regulation. It is our view that the State of New York should be a lot more aggressive than they have been. That summarizes one part of our report.

The last had to do with reviewing records; (1) in the New York City Department of Health; (2) in the office of the U.S. attorney, southern district of New York. We are very pleased with the cooperation we had from these groups, along with the New York Assistant Attorney General Charles J. Hynes.

The next thing we did was to manually evaluate the medical vendor statement, the so-called computer printout which has all the payments in New York State. When we asked for this printout, we requested what we had seen: A list that was alphabetized, a list that was in order by dollar amount. We wanted to learn how many physicians received how much medicaid moneys.

7 Percent Receive 50 Percent of Money

Subsequently we learned that 7 percent of the medicaid participating doctors earned 50 percent of the medicaid money. There is an incredible concentration of funds. Think about that—7 percent of the participating doctors received 50 percent of the medicaid dollars in New York City.

Now how did we learn that? That pile of papers you see at the end of the table is the computer printouts that they sent us. Now is it in some kind of order? Is it in order by alphabet? Is it in order by physician? Is it in order by dollar amount? The answer to that is

no. It is as if you told the computer to scramble the findings so as to confuse the Senate committee and its staff.

So we had to manually evaluate that pile of data, thanks to the people sitting behind me, we were able to do this. I would like to introduce to you at this point Arcole Perry, Suzanne Kaufmann, Stephanie Fidel, and Investigator Tom Cline. The staff has been working night and day going through the pile of computer printouts. We tried to find ways to run this through a computer. The Library of Congress was flabbergasted, they didn't know what to do with it. We had no alternative but to do our evaluations manually.

The next thing we did was to interview some 20 public officials. Thereafter, the chairman sent letters to every responsible public official in New York State. There were 30 public officials who received what may be called written interrogatories.

We also reviewed incorporated memoranda relating to the Illinois doctors we visited last January in conjunction with the subcommittee's report on clinical laboratory fraud. As the Senator from New Mexico knows, the doctors were very frank about their financial relationship, admitting receiving kickbacks of $1,000 a month or more from laboratories, in addition to receiving rentals of $1,000 a month from a pharmacy for an 8 by 10 foot room and $10,000 a month from the dentist for similar space.

Next we sent a questionnaire over the chairman's signature to 250 physicians in New York City who make between $75,000 and $785,000 from the medicaid program. The results of those questionnaires are just coming in. We have several physicians who are willing and anxious to testify before this committee with respect to various abuses.

Next the committee staff and the chairman, Senator Moss, posed as medicaid patients making some 200 visits to clinics in four States. About 120 of these visits occurred in New York City, the remainder occurred in the States of California, New Jersey, and Michigan. I would like to underline New Jersey because the Chairman of the Special Commission on Investigation, Mr. Rodriguez, is here today and he will present the results of his report and independent analysis of the medicaid mills.

The next step was monitoring the operation of the store front clinic established in Chicago last year.

Medicaid Mills for Sale

Lastly, we announced the establishment of a corporation to buy health care facilities. We simply answered advertisements in the New York Times. Every Sunday you will find three or four pages indicating medicaid mills for sale, along with invitations to physicians to join the medicaid mill and to make lots of money. We posed as businessmen trying to buy these facilities.

Essentially this is what we did in the course of this investigation. As the chairman pointed out in his remarks, perhaps our report has caused some confusion. The conclusions in this report deal with not only medicaid mills, but also with hospital and nursing home laboratories. It carries our conclusions, based on 7 years of dealing with the entire medicaid program.

At this point I would like to recognize the people who did most of the work in this investigation. On my right is Patricia Oriol, the

chief Clerk of the Senate Committee on Aging. I must say that we are indebted to Pat Oriol for a number of reasons. She is the chief clerk of the committee and keeps the committee on an even keel. In addition, she posed as a medicaid patient in some very dangerous neighborhoods. When we entered the 403d precinct, several policemen told us we were crazy. They told us that it is called Fort Apache, that nobody goes in there, but we were there, and Pat Oriol was right with us.

Another modest man who should be recognized is our staff director, Bill Oriol, to whom we are very much indebted for his assistance and guidance.

Next to Pat we have Mr. Darrell McDew of the U.S. Capitol Police force, Mr. James Roberts of the U.S. Capitol Police force and Catherine Hawes of the committee, who performed so admirably.

At this time with your permission I would like Mrs. Oriol to proceed and tell you what she found posing as a medicaid patient.

Senator Moss. Thank you, Val. Your full statement will be placed in the record.

[The prepared statement of Mr. Halamandaris follows:]

PREPARED STATEMENT OF VAL J. HALAMANDARIS, ASSOCIATE COUNSEL, SPECIAL COMMITTEE ON AGING

Mr. Chairman, we are pleased to be here this morning to present the results of our most recent investigation into Medicaid abuse. We focused on possible fraud by practitioners, including doctors and dentists and soon learned that most high-volume Medicaid practitioners work out of Medicaid mills. Consequently, Medicaid mills is the central topic of this report.

THE INVESTIGATION

In the course of this 8-month investigation Senate investigators attempted to test the Medicaid program from three perspectives: government, provider and patient. Specifically, the investigation involved:

(1) Examining in detail more than 100 major reports produced by Federal, State or local agencies detailing fraud, abuse, waste or inefficiency in Medicaid, with a particular emphasis on New York.

(2) Reviewing records in the New York City Department of Health, in the Office of the United States Attorney, Southern District of New York, in the Office of the District Attorney, County of New York, as well as offices of Michigan's Post Payment Surveillance Unit, the so-called "Fraud Squad."

(3) Manually evaluating the medical vendor statement, a computer print-out of all payments for 1974, compiled from records of the New York State Department of Social Services.

(4) Interviewing 20 public officials and sending written interrogatories to 30 additional public officials with present or past responsibility for the Medicaid program in New York.

(5) Interviewing more than 60 physicians; 50 of the interviews were conducted in Illinois last January in conjunction with the Subcommittee's report on clinical laboratory fraud.

(6) Sending questionnaires to 250 physicians in New York who were paid from $75,000 to $785,000 from Medicaid last year (1975).

(7) Committee staff and United States Senator Frank E. Moss, (see following), posed as Medicaid beneficiaries with valid Medicaid cards, presenting themselves for treatment more than 200 times. Some 120 of these visits were in New York City, the remainder were in California, New Jersey and Michigan.

(8) Announcing the establishing of a corporation for purposes of buying and operating health care facilities. Accompanied by cooperating physicians, investigators answered advertisements in the New York Times announcing "Medicaid mills" for sale in Brooklyn, Queens, the Bronx, and the lower East Side and East Harlem. This technique, along with the physician interviews, gave Senate investigators direct information as to the financial operation of numerous Medicaid mills.

(9) Monitoring the operation of a storefront "Medicaid mill" established last December by Chicago's Better Government Association.

Phase I of our work consisted of evaluating some 100 reports dealing with the operation of the Medicaid program particularly in New York. We found that the substantial problems have existed for some time. We then interviewed public officials and sent written interrogatories. We evaluated the results. Phase II was to incorporate the findings with respect to Medicaid mills which we learned in our examination of clinical labs last January in Illinois. Phase III related to our posing as patients and we would like to give you some detail on our experiences. Phase IV, which I will discuss in a few moments, related to our posing as businessmen answering ads in the *New York Times* ostensibly to buy Medicaid mills.

CONCLUSIONS

Maidcaid mills

Comparatively few physicians, (and other practitioners) the great majority of whom work in Medicand mills, are paid most of the money from the Medicaid program. However, because of complicated leasing arrangements, these doctors (mostly foreign trained practitioners) work essentially on commission and are allowed to keep only about 30 percent of the income they generate for Medicaid mill owners, generally businessmen and not medical practitioners.

Practitioners who work in Medicaid mills are under continual pressure to see more and more patients, to order more and more tests, and to spend less and less time with each patient. From personal experience Committee investigators and Senator Moss documented that the quality of care in Medicaid mills was poor in 90 percent of their visits.

As noted above, in national terms, about $2.2 billion may flow through such Medicaid mills. Some 70 percent of this amount is siphoned off by businessmen or real estate operators. Even allowing for overhead salary and other costs, the Committee staff concluded that $1 billion a year was being paid out unnecessarily to enterpreneurs who provide essentially no services.

Medicaid mill owners resort to many techniques to maximize the amount of income coming into the clinic, the first is billing for services not rendered (fraud) and the second most common is ordering unnecessary tests which is a form of over-utilization. However, in about 25 percent of the over-utilization cases experienced by the Committee staff, the efforts were so blatant, so calculated and purposeful, that the staff concluded they constituted intentional efforts to defraud the Medicaid program.

Medicaid mills: A box score

(1) $1 billion may be unnecessarily paid by Medicaid each year to businessmen and real estate speculators who own Medicaid mills. In the normal case, these men are not medical practitioners.

(2) Of the amount unnecessarily paid, the Committee staff estimates that $220 million (10 percent of all payments made to Medicaid mill practitioners or pharmacists) is outright fraud.

(3) Another $550 million of the $1 billion total (25 percent of all payments to Medicaid mill practitioners consists of purposeful over-utilization. The incentives under the present system encourage the ordering of repeated and unneeded tests and the provision of unwanted and unnecessary services.

(4) The quality of care in Medicaid mills in 90 percent of all cases is reprehensible.

NEW YORK

New York State, and particularly New York City has a historical problem of maladministration in its welfare (public assistance) and Medicaid programs (medical assistance) programs. The two are tied together because of eligibility for welfare automatically makes a client eligible for Medicaid as well. Studies by New York and federal officials continue to reveal high ineligibility rates and poor management. Despite repeated warnings from City, State and Federal officials in the form of over 100 reports (the best of which have been prepared by Comptroller Aurther Levitt), little action has followed. This is hardly news for New Yorkers who have read ad naseum about impropriety among New York nursing homes. This report suggests there is equal cause for alarm with respect to other Medicaid providers including some hospitals, clinical laboratories, and certain practitioners who work in Medicaid mills. The Committee staff used conservative estimates that $444 million is lost in New York State as a result of (a)

ineligibility, (b) fraud by all providers including nursing homes, hospitals and practitioners in Medicaid mills, and (c) overutilization of serves. Most of the problem is centered in New York City which the Committee estimates loses $295 million in Medicaid funds to these three factors.

While noting these problems are critical and that New York has the worst managed Medicaid program in the Nation, the Committee staff was quick to point out that the problems were historical and not the responsibility of any one public official. On the contrary, the Senate staff had high praise for Governor Hugh Carey of New York who has taken aggressive action to stem the tide. The staff report notes a few of the positive steps taken by Governor Carey: (1) the appointment of a Special Prosecutor for Nursing Homes and more recently vesting him with authority to examine domicilliary care facilities. (One prime recommendation of the report is that the Special Prosecutor's position should be established in law and that he be given responsibility to investigate practitioner abuse in the Medicaid program as well as among institutional providers); (2) the establishment of a Moreland Act Commission to study nursing home problems; (3) the establishment of a commission to study Social Services laws and (4) proposing and then signing legislation to establish a sophisticated computer system called the MMIS (Medicaid Management Information System). It is projected that MMIS may cut Medicaid losses by as much as $160 million a year in New York.

MEDICAID FRAUD IN GENERAL

After having examined fraud and abuse among nursing homes (with more than 27 hearings), clinical laboratories, some home health agencies, a few hospitals that specialize in welfare patients, and now having taken an extensive look at Medicaid mills, Senator Moss and the Committee staff concluded Medicaid fraud is massive. "The 8 percent estimate given by HEW is too low. Fraud is at least 10 percent—$1.5 billion out of $15 billion total. More likely it is about 12 percent ($1.8 billion)," as you have said, Senator, "Adding overutilization, we may be talking about 25 percent on the entire program."

STATEMENT OF PATRICIA G. ORIOL, CHIEF CLERK, COMMITTEE ON AGING

Mrs. Oriol. Mr. Chairman, my name is Patricia Glidden Oriol. I am 53 years old. From 1959 through 1960 I was chief clerk of the Subcommittee on Problems of the Aged and Aging of the Senate Committee on Labor and Public Welfare. From 1961 through the present I have been chief clerk of the Senate Special Committee on Aging.

Through 1959 to 1965 we on the subcommittee and committee were of course deeply involved in efforts which helped make the case for enactment of medicare. We were troubled by the fact that day in and day out older persons and the younger members of their families stood in danger of financial wipeout caused by hospital or medical bills and a few of us wondered whether medicaid—enacted as a compromise theoretically to cover gaps left by medicare and to give help to low income persons in other age groups—would really do all that was hoped for it.

This is not the place or time to recite what has happened to medicare or medicaid since but I will say that at committee hearings around the country during the past year elderly witnesses said again and again that medicare was letting them down in important ways: It doesn't cover prescription drugs, it is overly restrictive on home health, it doesn't pay for eyeglasses or hearing aids, and so on. They were, in effect, repeating a complaint heard by the committee soon after medicare was enacted. It is an umbella with many holes. And when asked about medicaid, many witnesses expressed misgivings about what they regarded as a welfare program, complete with a means test and redtape.

It was natural, I think, that I wanted to see what was happening to tax dollars voted by the Congress to achieve the purposes set forth when medicare and medicaid were passed 11 years ago.

I volunteered, then, to become a "shopper" at medicaid mills partially for the reasons explained by Mr. Halamandaris: It was important for a woman to join the investigative group, especially one who was older than the other participants.

Mr. Halamandaris has already described our shopping methods.

In my case I decided that it would be wrong to dress shabbily. People—especially older women—don't go to the doctor in their worst clothing; they try to make the best appearance possible. And so I wore inexpensive, but neat, clothing. I'm glad I did; I found out that most other women in every waiting room, no matter how poor or tough the neighborhood, did the best they could. Being poor doesn't mean the lack of pride; the opposite is more often the case.

But despite the efforts and attitudes of the patients, personnel seemed to regard the patients as unworthy and unfeeling objects, rather than people. There must be some sort of rule against calling a person anything but the first name. One of my medical files just has "Ruth" and the patient number.

Many Dollars—Little Care

Mr. Chairman, I sat more than once as doctors discussed business plans for new medicaid mills. I was only a few feet away; they didn't see me or even care about me. And they were completely frank about their determination to make as many dollars as possible for as little care as possible.

As I sat in waiting room after waiting room, usually scared, I became angry as well.

Here I was, in cities where many older persons are in desperate need of health care, and yet they can't afford it. The medicare deductibles or coinsurance may be too high for them; or they can't afford even the monthly premiums. And so medicaid should come to their aid. But go to a medicaid mill? Many elderly people, I am sure, have heard from others who had tried the mills and they had been warned. And I think that they would resent being used so that people who didn't care about them could cheat them and the Government. I saw very few older Americans at medicaid mills, and yet I know that good care, given by caring personnel, would have been a blessing to them.

I thought of hearings at which older people tell our committee that they can't afford to buy the prescription drugs that medicare doesn't pay for. I would think of that testimony when, at a medicaid mill after a cursory examination, I would be given three or four different prescriptions for ailments I did not have. I would think of that kind of testimony when a person who called himself a doctor urged me to take a tranquilizer or shot I did not need, insisting that it would make "a new woman out of you in an hour." Or, another one, "Your cold will be cured in an hour."

I thought of that kind of testimony later when Dr. Capper, disturbed because I had already convinced his aide that I would not take the two shots, approached me with the two hypodermic needles and said, "You can have them either in your hip or your arm." I was terrified

because my partner cop had finished and was waiting outside and could not get back through that buzzer door even if I shouted for him. I told the doctor I would take any medicine he prescribed but please don't give me shots, that if the medicine didn't work that I would take the shots when I came back in 2 days for the rest of the tests. He insisted that the injections were not penicillin and he wanted me to take them. I finally decided that if all else failed I would put up my hand and say, "Stop, I'm an investigator for the U.S. Senate." But after giving blood and the time to this clinic, I didn't want to blow my cover. So I was very grateful when he relented. However, on top of the two injections I had refused, I was given five prescriptions for medicine.

This experience both angered me and broke my heart. If I had been the poor, single person burned out of her apartment that I was pretending to be, I would have had no defense against such treatment. I would have received the shots without a chance of refusal. I would have been trying to recover from taking seven different kinds of medicine for my runny nose. And I could only wonder how much profit did Dr. Capper receive. And how many other defenseless patients are enduring the same experience right now?

Prescription Drugs and Pharmacies Pushed

That incident occurred in Detroit, but in all four states in which I shopped I encountered "pushing" of prescription drugs and the pharmacies are often just a few steps away from the medicaid mills, or you have to exit from the clinic through the pharmacy next door in order to get to the street. In fact, in California, in a very large clinic—Rockridge Medical Care Center—the pharmacy couldn't be missed. A wide blue line of arrows had been painted down the center of the sidewalk, across the street and right into the pharmacy.

And so, my pile of prescriptions mounted. I would walk out of the final medicaid mill and pharmacy at the end of the day and bring back in my shopping bag a load of medications that would do me no good at all. In fact, if I had taken the drugs that were prescribed for me I would probably have become desperately ill.

Today everyone is conscious of the danger of additives in our food and here these people are absolutely polluting patients' systems for profit.

At another clinic in Detroit, by an assistant, I was asked trick questions such as, "If you climb four flights of stairs, are you out of breath?" And I would have to answer, "Well, yes, a little." So the complaint was written down: Short of breath. Then I was asked, "If you walk four or five blocks, are you tired?" I would have to answer again, "A little bit." And the entry was: Fatigue. When the doctor started to talk to me he asked, "How long have you been short of breath and fatigued?" This doctor, Dr. Goldberg, was much more curious about my address and why I happened to be in his office than he was about my ills. When I told him it was close to Chandler Park, he asked if that was north or south of Woodward Street. I managed to evade answering the question because I didn't know, but I learned later that Woodward runs north and south.

This was the way of the medicaid mill: A test of wits if the patient was anything but subservient and unquestioning.

In 80 Delancey Street—Delancey Street Medical Center—on the lower East Side of New York, which was a long way from the Bronx address on my medicaid card—I wasn't as frightened there as I was humiliated by the manner of treatment. This clinic is open 7 days a week and I was told that the technician works 7 days a week. Another technician told me that she works part time because she is going to medical school.

While I was being examined, the door was left open to the public corridor and waiting room, and a young man entered the room and emptied the large trash can. The expensively dressed doctor, Dr. Gupta, during his quick examination—without a word—banged a TB tine test on my arm, barely missing the other two I had received from earlier clinics. If I had been offered the chance I would have refused the test because I'm not sure how many you should receive. No explanation was given as to what it was—no circle was put on the test area, nor was I told what to watch for. The needles from my blood tests were thrown in the waste can without being broken in two.

Between receiving my X-ray and the electrocardiogram, I was forced to sit in the public waiting room in the briefest, cheapest paper gown very much embarrassed in front of my buddies.

Optician—Glasses for Everyone

In the same clinic I witnessed an optician who received an urgent call and had to leave to go home, so he asked agitatedly for the files, saying, "I'm going to measure everyone whether they need glasses or not!" He then raced around with his little ruler measuring everyone, pulling the glasses off of one woman walking by and measuring her, and even measured a young baby 6 or 7 months old!

This type of experience was completely new to me. I have never been involved in any kind of undercover or secret investigation, let alone anything so dangerous. Without our good cops here, there were many streets where I would not have ventured alone out of the van and many clinics I would have been apprehensive about visiting alone. Our other investigators who were monitoring outside often had a tough time waiting around unnoticed on the street for the long waiting periods we spent in the clinics, yet when we finally emerged from the clinic—often alone—we could feel confident that we were being protected by our buddies.

In New York our staff worked alone, also in California. In Michigan and New Jersey we worked with State people who helped provide security and direction in our investigation.

Throughout I felt that patients were just being used. The patients—or more to the point, their medicaid numbers—were just the necessary raw material for the production of profits.

What a bitter and terrible thing to happen to them, so many of whom are already on the verge of hopelessness or dull resignation. I hated every moment I spent in those medicaid mills. I am the mother of and have raised five sons and have seen a wide range of injuries and illness, but our family has always had the advantage of fine medical care from Group Health Association of Washington. I watched young families all around me in the clinics and worried about whether the visit there would do the sick youngsters and adults more harm than good.

I hope that this hearing and the reports which accompany it can help make the case for reform. It haunts me to think, as we sit in this hearing room today, that at this very moment other persons are enduring what we endured—or worse—and that their poor treatment is making others wealthy.

My experience already seems like a fading nightmare. For me, the memory recedes; for other, it is a harsh, everyday reality.

Senator Moss. Thank you, Pat. You have testified rather eloquently there and I appreciate it. It gives us the feeling of what it is to go into those clinics which the record will show you accompanied me when I went in there and I was glad to have you along because you were a veteran and I was a neophyte. You recognize the feeling of agitation and deep sadness as you sit there for an hour or two just looking at those people crowded in there, oftentimes not enough chairs for everybody to sit down and all going back and forth out through the little bathroom that is outside that is a public lavatory, taking their kids in and out. The place is not fit to enter. It really is a time of sadness.

I am sorry to interrupt you but it touched my memory.

Mr. Halamandaris. Thank you, Mr. Chairman.

We would like to have Officer McDew continue at this time.

Senator Moss. All right.

Glad to have you. Officer McDew. You were on hand all of the time just outside or inside and I appreciated your presence there in New York.

STATEMENT OF DARRELL R. McDEW, TEMPORARY INVESTIGATOR, COMMITTEE ON AGING

Mr. McDew. Good morning. Mr. Chairman and Members of the Senate. I am Darrell R. McDew. Starting on May 12, 1976, I began posing as a medicaid patient along with other members of the staff of the Committee on Aging.

Over the next few months, I and the other five members of the team made more than 200 visits to practitioners in medicaid mills in four States.

All of us began this assignment with mixed emotions. I didn't know quite what to expect. We had no conception of the quality of medicine that was being practiced and how it compared with our family physicians or other public health clinics. We had heard about various abuses allegedly practiced by some doctors but didn't really know what people were talking about.

After 3 months all of us were thoroughly educated in the terminology. For example, all of us personally experienced an abuse called ping-ponging. Ping-ponging is the practice of referring patients from practitioner to practitioner in the same facility irrespective of need.

In some facilities we entered, ping-ponging was obvious and apparent, a premeditated policy. I would like to tell you about a few of my experiences in a little more detail.

Imagine you are with me walking into the East Harlem Medical Center. I told the receptionist I wanted to see a doctor about my feet. After waiting a while I was ushered in to see what I thought was the

podiatrist. The man turned out to be a general practitioner, Clyde Weissbart. At no time did he examine my feet. Instead he asked a few questions about my medical history, checked my back with a stethoscope and asked me if I ever had any back trouble. He then prescribed three medications, and ordered urine and blood tests and X-rays. Dr. Weissbart asked me if I used any particular pharmacy and I told him no. He then asked if he could suggest one, and I told him he could. He told me that the pharmacy next door was a good one and that I should get my prescriptions filled there. He repeated this several times.

When he gave me my chart, he told me to go upstairs. Again, I assumed I would be seeing the podiatrist. However, when I got upstairs I discovered that I was in the waiting room of the chiropractor, Dr. Abbot Cohen. He asked me if I had any problems with my back and I said, "Not really." He examined me and said my spine was crooked, pressing his fingers on my back.

"Your back does hurt you here, doesn't it?" he said.

"Yes," I said: "With you pressing it, it does hurt, but it quits when you stop." [Laughter.]

"Well, I think with six or seven visits, I can straighten you out," he said, suggesting my first visit start the next day.

Feet Examined Visually

After this examination I was directed downstairs where I finally saw the podiatrist, Dr. Napoli, about my feet. I told him my feet hurt, particularly the soles. He had me sit on a bench and take off my shoes and stockings. At no time did he place his hands on my feet. He sat in his chair across the room with his arms folded. By just looking at my feet he announced his diagnosis—"ankle strain." "When you get up in the morning you feel like you're walking on eggs, don't you," he asked.

I said, "No, not really." [Laughter.]

He insisted I probably felt like I was walking on eggs each morning and that I had strained ankles. He wrote a prescription for one pair of ankle braces fitted to size. He never told me when to start wearing them or for how long, just to fill the prescription at a medical supply house down the street and to return in about a week

I think you can understand why the phrase "ping-pong" is accruate. All of us repeatedly were bounced through the medicaid mill. Always the visits were brief. About 45 percent of the visits resulted in at least one referral or "ping-pong."

Perhaps another example or two will further make the point. At the Riis-Wald Medical and Dental Center, I complained of a headache. The receptionist asked me if I wanted to see a podiatrist or a chiropractor. I said: "No, you didn't hear me. I said I have a headache."

She told me that because of my headaches I needed to see a chiropractor. "Maybe your headaches are caused by tension," she offered.

I saw the chiropractor, Dr. Diniz. He asked about my medical history, he examined me, gave me an "adjustment" on my back and ended by cracking my neck. He sent me back to the waiting room. Not long after this I was called in to see another practitioner. He was

a podiatrist, Dr. Jackowitz. He looked at my feet and said, "Your feet sweat." I looked down at my grubby tennis shoes and remembered that it was in the 90's outside. I didn't say anything as he gave me a medication which he claimed would decrease the sweating. After having me stand barefoot on the floor, he diagnosed flat feet and hammer toes. He placed small white pads in the arches of my tennis shoes. Here they are [indicating].

Senator Moss. It looks like about the size of a silver dollar.

Mr. McDew. After another trip to the waiting room, I was called in to see Dr. Ortez, an internist. He asked me how frequently I had headaches. He told me I have to have X-rays. I submitted to about 10 of them. I was scheduled to return for further tests but nobody told me why they were needed.

An interesting postscript to this visit illustrating the "ping-ponging" we received is the fact that I encountered Dr. Jackowitz, the podiatrist, about 1 week later. This second meeting took place at the Urban Medical Group in Harlem. I had asked to see a doctor without specifying a complaint. He asked what my problem was and I said nothing except maybe my feet hurt a little. The doctor was making an examination when another practitioner stuck his head through the curtains of the cubicle. He asked my name and I responded. He told me he was the optometrist and that I should be sure to see him before I left. Minutes later the podiatrist came in the room and I recognized him at once. It was Dr. Jackowitz.

He looked at me and then at my feet. While looking at my feet he asked me, "Haven't I seen you before?" I didn't say anything. He pulled out a little book and said, "Yes; I did see you on the lower east side a couple of weeks ago."

Glasses Prescribed—Vision 20/20

Looking at me he said: "Remember what you had before? Well, you've got it again." [Laughter.] He placed little white pads in the insoles of my oxfords. To finish the story, I did see the optometrist. He told me I needed glasses and prescribed a set for me. He gave me a choice of the two standard medicaid frames and noted that if I wanted to pay a few dollars extra, I could get special frames, wire rims or other kinds of metal frames.

I should add that my vision is 20/20 and my feet and body are completely healthy.

My overwhelming impression is one of gratitude. I am grateful my financial situation does not require me to depend on medicaid for my medical care. I honestly feel, and the other investigators who are testifying today will agree, that if I had a serious illness it would remain undetected or untreated. I am sad to think that there are many people who have not been as lucky as I. They must encounter on a daily basis the horrible conditions and treatment that I experienced during this investigation.

[The prepared statement of Mr. McDew follows:]

PREPARED STATEMENT OF DARRELL R. McDEW

I, Darrell R. McDew, private with the United States Capitol Police, was placed on temporary leave of absence by resignation in order to be hired by the Special Committee on Aging of the United States Senate on May 7, 1976. I

reported to the Committee on May 7, 1976, and was sworn in as a Senate Investigator. On this date, I was examined by the attending physician of the United States Capitol, Dr. Freeman H. Carey. Dr. Carey certified that I was in excellent health with no medical infirmities, at that time.

During the period of May 10 through July 16, 1976, I participated in an investigation evaluating the operation of the Medicaid programs in New York, Michigan and New Jersey, and the Medi-Cal program in California. I posed as a Medicaid beneficiary and presented a variety of possible illnesses to various doctors in facilities that accepted Medicaid patients. My complaints included those of a general nature, such as headaches, foot problems, back pains, eye problems, and common cold. During these 10 weeks, I was seen by internists, podiatrists, opticians, opthalmologists, optometrists, chiropractors, and general practitioners.

Of the many visits I made to these facilities, there were several instances in which I felt the treatment I received was worse than poor. There were times that I felt no more human than a dog as I was sent from doctor to doctor and test to test without so much as an explanation. Medications were prescribed liberally, and in most cases I was not told what type of medication I was supposed to take or the possible reactions I could experience due to intake. I hope the following illustrations will clarify the frustrations I felt as a Medicaid recipient.

When I entered East Harlem Medical Group in New York City, I requested to see a doctor about my feet. The receptionist took my Medicaid card and told me to take a seat. After waiting a while a doctor motioned me into an examining room. At that time, I assumed that this doctor was the podiatrist. However, at no time did this man examine my feet, and it was not until the conclusion of the examination that I learned his name and specialty. The man's name is Dr. Clyde Weissbart. He gave me a very brief examination consisting of checking my chest with a stethoscope and asking me if I was having problems with my back. He then prescribed three medications, ordered a urine sample and a chest x-ray, and scheduled me for blood work. Dr. Weissbart asked me if I used any particular pharmacy and I told him no. He asked if he could suggest one. I answered yes. He told me that the one next door was a good pharmacy and that I should get my prescription filled there. He repeated this to me several times.

When he gave me my chart, he told me to go upstairs. Again, I assumed I would be seeing the podiatrist. However, when I got upstairs I discovered that I was in the waiting room of the chiropractor, Dr. Abbot Cohen. While waiting to see Dr. Cohen, I opened my clinic folder and read the chart. I saw that Dr. Weissbart had noted that I had no allergies. However, Dr. Weissbart had never asked me if I had allergies. In fact, I do have one allergy, to horse serum.

My examination with Dr. Cohen lasted approximately 10-15 minutes. He asked me a few questions about problems I have had with my back. I said I haven't had any, only on very rare occasions, a strain or stiffness, but nothing serious. He had me take my shirt and undershirt off, and began to examine me. He told me that my back was in very bad shape. Dr. Cohen said that rather than being straight in the lower section, my spine pointed towards the front and right of my body. He pressed his finger against the lower part of my back and stated, "Your back does hurt you there, doesn't it?" I said, "Yes with you pressing as you are, it does hurt, but other than that, it doesn't." Then he said, "Well, I think in maybe six or seven visits with me, I can straighten you out." He suggested that the first visit be the following day.

After this examination, I went back downstairs to the waiting room and finally saw the podiatrist, Dr. Napoli. When asked what my problem was, I complained of pain in the soles of my feet and in the back of my calves. He told me to take my shoes and socks off and sit on the bench. At no time did he ever place his hands on my feet. He sat in a chair about three feet way, with his arms folded, and just looked at them, saying that there was something wrong with my ankle. He called it ankle strain. He said, "When you get up in the morning don't you feel like you're walking on eggs?" I replied, "No, not really." He still insisted that I probably felt like I was walking on eggs in the morning and told me once more that I had strained ankles. At this time he began writing out a Medical Service Order for one pair of ankle braces fitted to size. He never told me how long to wear them, nor when I should start wearing them. He did tell me to come back in a week.

PING-PONGING PRACTICED

My experience at Riis-Wald Medical and Dental Center provides another example of the practice of ping-pong, being sent from one doctor to the next regardless of a patient's initial complaint. I went in this facility and complained of headaches. The receptionist was very courteous and nice. The place as a whole was very clean and seemed to have been well organized.

The receptionist asked for my Medicaid card and I presented it to her. She said, "Have a seat and then I'll call you back." I assumed that during this time she had run off copies of my card, since when she called me back, I looked down and saw she had a folder in which there were two copies of it. She asked me if I wanted to see a podiatrist or a chiropractor. She said, "Because of the headaches you may need a chiropractor. Maybe your headaches are due to tension." I said, "Well, I'm not sure, but you think I need to see him, okay." She replied, "I think it might be a good idea." Then she asked if I was having problems with my feet and I said, "Well, not really." She asked, "Well, do you want to see a podiatrist?" I just shrugged my shoulders and said, "Well, I'm not sure." She said, "Well, I'll put you down to see one."

While I was waiting to see the doctor about my headaches, I was called in to see the podiatrist, Dr. Jackowitz. The doctor examined between my toes and said, "It seems like your feet sweat." He gave me a prescription for some kind of medication which he claimed would decrease the sweating. Then Dr. Jackowitz requested that I stand barefoot on the floor. He glanced briefly at my feet and diagnosed flatfeet and hammer toes. He placed small white pads in the arches of my tennis shoes and said, "I'll put these little pads in your shoes and you see how that feels." I noticed no difference with or without the pads. The entire examination with Dr. Jackowitz lasted approximately six or seven minutes.

I returned to the waiting room for a short period of time, after which I was called in to see Dr. Ortez. He apparently was the doctor that I was to see about my headaches. First I saw someone whom I assumed to be his nurse. She took a fairly complete medical history, including questions concerning asthma, epilepsy, paresis, high blood pressure, sugar diabetes, and my drinking habits in regards to alcohol, coffee, and water. She also checked my blood pressure. Then I waited for the doctor. He came in, asked me a few questions, took my blood pressure, reached inside my shirt and felt around my chest and back area with stethoscope. He asked me how frequently I had headaches, and how long had I had them. Then he questioned me about my sleeping patterns. After he had finished the examination he told me he wanted to have x-rays taken. I submitted to about 10 of them. I was also scheduled to return for further tests but no explanation was given as to why I needed them.

Once again, I returned to the waiting room and was summoned in to see Dr. Diniz, the chiropractor. He took my blood pressure, listened to my chest area with his stethoscope and felt around my spine from the base of my skull to my waistline. He asked me how I felt, did he hurt me at anytime during the examination? I said no. Then, he had me lie face down on the examining table and applied little pressure on my lower back and asked if he was hurting me. He had me turn my head to the right, and pressed down on it around my neck area, and he asked me if that hurt. Then he repeated the same thing to the left side. Finally, he said, "Well, you seem to be tense. Are you tense or nervous about anything?" I answered no to all his questions. He said, "Well, it feels like you are very tense." He then cracked my neck a couple of times. After what seemed to be a very long time, I left the clinic.

On May 25, I entered the Urban Medical Group, less than two weeks after having visited Riis-Wald Medical and Dental Center. Upon entering, I asked to see a doctor without specifying my problem. The receptionist told me to take a number and have a seat. After a while, I was called back to the desk where the receptionist requested my Medicaid card. She made approximately 8–10 copies of my card.

I was called into an examining room and a person, whom I assumed to be a doctor, came in. He never identified himself by name and began asking me some brief questions about my medical history. Finally, he asked me what my problem was, and I told him that I was having problems with my feet—that they were hurting all the time around the sole area. At this time, he told me to take off my shoes and socks and sit on the examining table. He felt the pulse in my feet and said it felt good. He mentioned that he probably would want to run a test to see if I had sugar diabetes or anything of that nature.

PODIATRIST SPLITS TIME BETWEEN MILLS

At this time, Dr. Jackowitz, the podiatrist who had examined me at the Riis-Wald Medical and Dental Center, happened to stop by the cubicle. The other doctor asked Dr. Jackowitz to take a look at my feet. He told me to stand on the floor barefoot. Dr. Jackowitz said, "This man's problem is just the fact that he has flat feet and there's nothing more." The first doctor mentioned, "Well, do you think it's necessary for me to run any tests?", at which time the podiatrist said, "No, his only problem is flat feet."

Dr. Jackowitz told me to follow him into his examining room where he checked my feet a little closer and put some padding in the arch area of my shoes. He then mentioned to me that he recalled seeing my face and told me that my voice sounded familiar. He asked me if I was sure I had not been to a medical center on Avenue D. I told him that to the best of my recollection I had not. Then, he looked at my chart and noted that the symptoms I had were also very familiar to him. He asked me if I had been in the service and I said, "Yes, I was in the Navy." At this point, he was even more sure that he had seen me and said, "Hold on a minute, "I'll check." He looked into a notebook filled with a list of names and found the name Tomas Feliciano. Then he remembered seeing me at Riis-Wald Medical and Dental Center, earlier that month.

While I was in the podiatrist's office, the optometrist stepped into the office and said to me, "Come and see me when you're finished here. I'm the optometrist."

After the podiatrist finished putting the pads in my shoes he told me to come back and see him next Thursday.

Then I went into the optometrist's office and he examined my eyes. He had me read the eye chart without the aid of any lenses. Then he used a machine and had me read the chart again while switching different lenses back and forth. Everytime he chanked the lenses, he would ask me if I could see better or worse. Finally, he said to me, "Generally, your eyes are pretty good, but you do need reading glasses." He asked me if I wanted to pay for special frames, or make do with Medicaid frames.

At Avenue C Medical Group, located on the Lower East Side, I walked in and asked to see a doctor. The receptionist asked me my complaint and I told her I was having headaches. She asked for my Medicaid card and told me to have a seat.

I waited for what seemed to be a long time. Then, she called me back to the desk and asked me if I wanted to see an optometrist. I replied, "I don't know." She said, "Well, you may be straining your eyes and that may be one of the reasons that you are having headaches. You may need glasses." I just shrugged my shoulders. She said, "Well, I will fix it up that way. You will see the doctor and then see the optometrist." She told me to have a seat again. Once more the receptionist called me back and told me that the first doctor I was originally supposed to see was out to lunch, so I would be sent in to see Dr. Barron, the optometrist first.

The first thing he asked me to do was read the eye chart. Next, the doctor held various lenses with one hand in front of my eyes, while he directed a light through the lenses into my eyes with his other hand. At no point during this part of the examination did he ask me to read the chart. Finally, he placed two lenses into a frame, put them over my eyes, and had me read the chart. He stated, "Your eyes are a little bit off here and there. You need glasses, so I'm going to write up a prescription. You can get plain glasses through Medicaid, but I suggest that you get tinted glasses. This will cost you a little more, but where I'm going to send you, the guy is pretty fair. For a few extra dollars he can fit you with some tinted glasses." I was told to come back to see a Dr. Larry.

I did return on the scheduled day to see a Mr. or a Dr. Larry to be fitted for eye glass frames. He showed me frames of various kinds and colors. I asked him if it was possible to get metal frames, and he stated that Medicaid does not pay for them. So, I chose a brown colored frame. He then wrote up a work order on that particular set of frames, and stated that I was to come back in a few days to pick up my glasses. I obtained these glasses and they have been refracted and are secured in a safe in the offices of the Committee on Aging.

I would like to make note that, to my knowledge, I have 20–20 vision. My last eye examination was prior to going on the U.S. Capitol Police Force in January of 1974. At that time, I was told that I needed no visual aid.

After Dr. Barron's examination, I returned to the waiting room and was eventually called in to see Dr. Markowski, an internist. He took my blood pressure,

my temperature, checked my throat, and asked me if I was allergic to anything. I told him that I was allergic to pencillin. He suggested that I have a B–12 shot and I told him I didn't want it because I don't like needles.

TESTS PUSHED

He also scheduled me for tests later on in the day. From what I saw on the doctor's invoice, he had about nine items listed. I returned later that day and gave a urine sample and three vials of my blood were drawn. I was also scheduled for an EKG, but I did not have it.

At Universal Medical Group my complaint was "achey" feet. Dr. Feldman, the podiatrist, examined my feet, felt around my ankles, toes, and calves. He asked if I had sugar diabetes, anemia or heart trouble. He x-rayed my feet in a flat position and also at an angle. He stated that my feet were in pretty good shape, but I needed arch supports. He took a plain sheet of paper and placed it on the floor, tracing my right foot on one side of the paper, and the left foot on the reverse side. He made two small marks on the paper at the point where the toes begin. He said the x-rays would substantiate the need for foot molds. He asked me if I had a phone and I answered no. So, he told me that he would send me a letter when the molds arrived and to be sure to come back to see him.

I entered the 164th Street Medical Group and again complained of headaches. I was seen by Dr. Enrique Davis who gave me a brief examination using a stethoscope on my back and chest and asking brief medical history. He took my height and weight. I was given an allergy test, vials of blood were drawn, and I gave a urine sample. I was scheduled for x-rays and an EKG, which I did not have since the clinic was about to close and I was told to return the next day. The clinc was very large, clean and well situated and the staff seemed to be well trained.

On my second visit to this clinic, a week and a half later, the atmosphere had changed. I noticed that there were a number of people who seemed to be addicts hanging around inside and outside the clinic. Again, my complaint was headaches and inability to sleep. Dr. Davis read over my chart from the first visit and told me that the results from my tests were okay. However, he went ahead and prescribed three medications and at this point, he still had not told me what he thought to be the cause of my headaches.

At the Willis Professional Group I again complained of headaches. I was throughly examined by a doctor by the name of Wallace. She took my blood pressure, checked my eyes, ears, nose and throat and listened to my chest and back area with a stethoscope. She felt around my abdominal area, ankles, calves, and throat. She had her assistant take my weight and height, and also had me read the eye chart. She determined I had 20/20 vision. Dr. Wallace told me that she could not see any physical reason for my headaches. She asked what I usually do when I have these headaches and I told her I take Excedrin and drink coffee. She told me she would not prescribe any medication, but to continue as I had been. She told me to return if I experienced any blurred vision or nausea. She said the headaches were probably due to tension and nothing more.

Dr. Wallace was efficient and took her time examining me. She seemed interested in me as an individual rather than as a nameless face. Of all the doctors that I visited throughout the investigation, she was the only one to give me a diagnosis with concurred with my true physical state.

Probably the most frustrating experience of the entire "shopping" venture was the endless waiting I endured in order to receive treatment. In one facility I sat for at least three and a half hours after which time I became so angry, I left. I watched as doctors walked around the clinics socializing with the receptionists and nurses instead of taking care of patients.

The filth and stench in a large majority of the facilities I visited was disgusting. I found it very upsetting to see cockroaches crawling on the floor of a medical office. The walls were dirty, cigarette butts littered the floor, and ashtrays were overflowing. Where there were stairs, they were so rickety that I had to be extremely careful when walking up or down them. The lighting in the waiting rooms was so inadequate that it made the waiting rooms appear even more dismal and depressing than they already were. One doctor's fingernails were so filthy it seemed like he had just come from changing the oil in his car.

In most instances when doctors prescribed medications for me, I was not told what kind they were nor how to take them. Nor was I told what to do if I experienced any type of reaction.

I would like to conclude by saying that I feel extremely grateful that I am not in a situation which requires me to depend on Medicaid for my medical care. I honestly feel that if I had a serious illness, it would remain undetected and untreated. I am saddened to think of the many people who have to endure the kinds of treatment and conditions that I experienced during this investigation.

Senator BEALL. When you had the 10 X-rays for the headaches, what part of the body was X-rayed?

Mr. MCDEW. The 10 X-rays consisted of four skull X-rays, chest and back and also of my feet.

Senator BEALL. Your feet?

Mr. MCDEW. Yes.

Senator BEALL. Thank you.

Senator MOSS. Thanks very much.

Mr. HALAMANDARIS. Officer Roberts.

STATEMENT OF JAMES A. ROBERTS, JR., TEMPORARY INVESTIGATOR, COMMITTEE ON AGING

Mr. ROBERTS. Good morning, Mr. Chairman and Members of the Senate. I am James A. Roberts. Starting on May 12, 1976, I began posing as a medicaid patient along with other members of the staff of the Committee on Aging.

Our investigation carried us from the lower East Side of Manhattan all the way to sunny Oakland, Calif. Yet, no matter what State we were in, there was always one thing that was consistent and that one thing is that these "medicaid mills" were always located in pockets of poverty. They were as strategically placed as sentries around the White House. Common logic would dictate that competition for patient load would be fierce, since there were so many clinics in any one small area. Continuing with that line of reasoning one would think then that the personnel would try to provide high quality care to attract the patients. Unfortunately, we did not find this to be so. If anything, our treatment demonstrated that we were thought of as being expendable.

A medicaid patient is almost always forced to surrender his rights as an individual to the clinic personnel. Officer McDew described the practice of ping-ponging, a practice which we all experienced. The purpose of ping-ponging is to bolster the clinic revenues and not, in my experience, to provide preventive health care. I would like to describe a related treatment mode. I refer to the ordering of medical and laboratory tests, many of which are unnecessary, poorly administered, and occasionally even dangerous to a person's health. These tests also appear to be done only to increase clinic profits, not to improve patient care.

I would like to give you a few examples which illustrate these points.

I entered the Gouverneur Medical Clinic in Manhattan complaining of a burning feeling when I passed water. During the examination, which was only from the waist up, the doctor told me that she detected a slight heart murmur. She told me that I would have to have an EKG to confirm her findings. As I was lying on my back, with the EKG test in progress, the doctor without warning jabbed my outstretched arm with a series of needles in what is called a Tine test for TB. I am sure that this shock had an effect on the EKG

tracing; however, the doctor dismissed my concern by telling me that this procedure was required by the Health Department for all new medicaid patients. The doctor circled the area with her ball point pen but I was given no further instruction as to what I should look for.

The important point is that two other investigators entered the same clinic. They, too, were told that they had heart murmurs, given EKGs and a battery of other tests. I found out later that an EKG is not standard procedure to verify a heart murmur. Since we were all healthy the entire procedure, including the finding of the heart murmur, was not medically indicated; rather, it was obviously a way of increasing income to the clinic from medicaid.

Tests, but No Results

A similar incident occurred at the 164th Street Medical Group on Morris Avenue in the Bronx. I presented a complaint of an earache and a cold. I was told that since this was my first clinic visit, I would need to have an allergy test. Even before I had seen a physician, I found myself again being jabbed with needles. This time there were 30 needles on a board in 3 rows of 10. The attendant took one drop from each bottle on her tray and placed it on each of the punctures. In a few minutes she wiped my arm clean.

I was never told the results of this allergy test. In fact, none of the clinic doctors or any of the clinic personnel so much as looked at my arm for a reaction.

At the same clinic I was given a test which measures hearing loss and told that this procedure was required since I complained of an earache. I was never told the results of this test either.

At the Riis-Wald Clinic in Lower Manhattan I complained of a burning feeling when I passed water. The receptionist directed me to the chiropractor. The chiropractor told me that full body X-rays were necessary. In his words, "Sometimes one appears to be healthy on the outside but X-rays are necessary to get a picture of what is going on in the bones."

The podiatrists I saw were also prone to order X-rays for questionable reasons. One told me that I had a bunion on the big toe of my right foot. Another told me that I had a bunion on the big toe of my left foot. Both said that they had to take X-rays to make sure.

If I can offer a few generalizations:

(1) A wide variety of tests were ordered on most visits. Blood was almost universally asked for.

(2) Quite often the tests had nothing to do with the symptoms that we presented. When I asked one doctor what the correlation was between an earache and a blood sample, he became visibly upset. He said that I had to give him blood or he would not treat me.

(3) The tests were usually rushed and at times haphazardly given. We were given EKGs over stockings and our blood pressures were taken over our shirt sleeves. When listening to our chests and back, often the doctors didn't bother to have us remove our shirts.

(4) Rarely were we given the results of the tests we received.

The psychological trauma of this 3 month experience was severe. In the back of my mind I always knew that I was not dependent

on these horrible clinics for my regular medical care but I am still troubled and saddened when I think of all the people in this country who really don't have any other alternatives.

[The prepared statement of Mr. Roberts follows:]

PREPARED STATEMENT OF JAMES A. ROBERTS, JR.

Mr. Chairman, my name is James A. Roberts, Jr. I am a Private in the United States Capitol Police. Our investigation carried us from Manhattan's Lower East Side all the way to sunny Oakland, California. Yet no matter what State we were in one thing was always consistent. That one thing is that these "Medicaid mills" were always located in pockets of poverty. They were as strategically located as sentries about the White House. Common logic would dictate that with such a number of clinics there ought to have been some competition among the centers for patient load. If a person's actions are indicative of his thoughts, then that thought is as far removed from their minds as a cat swimming in the Atlantic Ocean, because they treated us as though we were expendables.

I think that the best way to illustrate the conditions we encountered in our investigation, is by giving a number of illustrations of what transpired during the visits.

When I went to the Gouveneur Medical and Dental Group, I asked to see a medical doctor. The receptionist asked me what my problem was and I told her that I had a burning feeling when I passed water. She then asked for my Medicaid card—no identification—and made at least two copies of it.

I was given a dental clinic card even though I never asked for it and was there to see a medical doctor. Then there was a short wait—probably about ten minutes—before I was directed to an examining room and to a Dr. DeJesus. Dr. DeJesus asked me what my reason was for being there, and I told her that I had a slight burning sensation when I passed water. She then asked me if I was certain that there wasn't any discharge and I said yes. She asked if I was allergic to any medication and I told her that I was allergic to penicillin. She was writing on the chart the whole time that she was speaking to me. She then asked me to pull up my shirt and undershirt. She took a blood pressure reading which she said was normal. She then listened to my chest and heart. While listening to my heart, she said that she detected a "slight murmur," and I would have to have an EKG test to verify her findings. I was taken into a room where there was an examining table, and an assistant who applied the creams and began the EKG exam.

While I was on the table, and the EKG test had just started, Dr. DeJesus came into the room and without any warning, she popped me with a Tine TB test on my outstretched wired arm. I asked her what that was because it surprised me. She responded that it was a "TB test that was required by the Health Department of all new Medicaid patients." So I did not object because I did not have a chance to do so.

She circled the test area on my arm with a ball point pen, but she did not give me a specific time to return to have it read. I was not given any instructions as to what to watch for, nor was I told to report any changes to her.

After the EKG test was over, the technician told me to get dressed. Then she came back into the room and gave me a cup for a urine sample. I remembered hearing Dr. DeJesus telling the technician that she wanted me to have a urine test and that I was supposed to come back the next Saturday for a reading of the urine specimen.

When I gave the sample to the technician, she said that Dr. DeJesus said that my EKG was normal, but as I was leaving, Dr. DeJesus stopped me at the reception desk.

She seemed rather interested in my skin. She kept looking at my face and saying that there was something wrong with my skin because it looked scaly to her. I just told her that I didn't put any lotion on it that day, that I had just gotten up off of the street and come in.

After the receptionist told me to have the prescriptions filled at the pharmacy next door, I then left the clinic.

The next office (if you can call it an office) I went into was at 209 East 14th Street. From the street the place looked to be a door leading to nowhere that you would ever want to go. Yet there was a large blue awning stretched

out front that said "14th Street Medical Center." When you entered the office, you found that it was very dimly lit. The furnishings look as if they were taken directly from a junk yard. Somewhere from behind the partition came a voice that asked me what I wanted. I later found out that the voice belonged to a man dressed in a white uniform. When I told him that I had a burning feeling when I urinated he promptly referred me to the City Health Department Clinic. This, I might guess, was the best treatment that one could possibly get from this clinic. So, heeding his expert suggestion I turned and left. I got the same treatment on two return visits.

I wouldn't send a dying dog into that place. This was one of the worst looking places that I saw in all of my "shopping experiences."

EXAMINATION: 30 SECONDS

At the Third Avenue Medical Office, I received the fastest exam of my eyes, ears, nose and throat that I have ever experienced. I was complaining of an earache—that I had some mucous draining—and that I had been suffering for a day or two.

The doctor that I saw here was named Bernard. He asked me very general medical questions, about my medical history and the medical history of my family. I responded negatively to all of his questions, but I did tell him that I had an aunt who had diabetes. It wasn't until after he had taken my blood pressure that he got around to asking me why I was there.

He then took an instrument and looked into my eyes, ears, nose and throat, covering all of these areas in about thirty seconds. And that is a generous estimate; it may be more like ten seconds on the outside. This particular exam was the fastest one that I have ever had.

He next instructed me to lie up on the examining table. Dr. Bernard took his hand and ran it across my left and right ankle, just touching them. He asked me to unbuckle my pants, and he pressed around my abdominal area. He visually examined my chest area, and then told me that I could stand up.

I fastened my clothes and sat down in the chair next to him. He took my temperature, and reported it to be 99.4, even though I do not believe that I had a fever at that time. I was not feeling flushed, feverish, or any other discomfort.

It was at this point that he brought out two test tubes and a syringe so that he could take a blood sample. I refused to take the blood test and the doctor became visibly upset. He said that he didn't want to continue treating me, since he would not be able to tell what was wrong with me, unless he had a blood sample. I questioned him about the correlation between a blood test and an earache, and he said that the blood test was to determine whether or not I had diabetes. He said that since I had an aunt that had diabetes, I had a history of the disease in my family. He also rattled off other reasons for having a blood test, that I couldn't fully understand because of this thick accent. But again I refused to have the test, despite his insistence, because I did not trust him or appreciate his rough manner.

He offered to give me a prescription to relieve the pain and discomfort in my ear but he told me that I would have to be referred to another doctor or hospital. He refused to accept any liability for what may have been wrong with me, and with that, began to write furiously all over the chart. I think that he spent more time writing on my chart than actually examining me! He filled in every conceivable space that was on the examination chart, and when he finally finished, he wrote out a prescription for two medications which he placed in my folder. I was ushered back to the reception area, where the receptionist filled out the top of the prescription forms, and gave them to me. After that, I left the office.

The 164th Street Medical Group at 95 Morris Avenue was a new facility that still wore banners announcing its grand opening, like a used car lot. However, it seemed to have the full range of practitioners from surgeons to chiropractors, hearing specialists, psychiatrists, allergists, podiatrists, internists, dermatologists, and radiologists.

I entered the clinic and was greeted by a man in a white smock. He asked me why I was there and I said that I wanted to see a doctor. He asked if I had been there before and when I responded negatively, he said that he would start a file on me. This included taking my Medicaid card and making six copies of it.

After that, he said that since this was my first visit, the first thing would have to be done would be an allergy test. After a brief wait, an assistant took me

into the nurses' station and gave me the test. First she washed the underside of my forearm with alcohol. Next, she took a device that had about thirty needles on it and ran it into my skin causing multiple penetrations. Then she took one drop from each of the thirty bottles on her tray and went over the skin pricks that she had made and let it sit for a while.

I would like to make note here that after the technician wiped the drops off of my arms, no one ever took any real notice of what the reaction was, if any, that I had to the scratch test,

When she was finished with the allergy test, the technician took me into the medical examining room where I was seen by Dr. Enrique Davis.

He asked me why I was there and I repeated what I had told the male receptionist, that I had an earache the day before and that I had a mucous problem.

The physical exam itself was very brief. Dr. Davis asked me questions about my medical history and about my family's medical history. At this point, Dr. Davis stopped writing and looked me in the eye and asked me where I came from. I responded by giving him the same address that was on my Medicaid card. That answer was not what he was looking for as he asked me where I was really from. I was frightened, swallowed hard, and told him that I was born in Newark, New Jersey, but had moved to New York about five years ago. Dr. Davis slowly turned his pen in his hand as he thought about my response. By that time, my palms were sweaty and my heart was beating a little bit faster. But that answer seemed to suffice.

Many Tests—Poor Care

His assistant continued the examination. She weighed me, measured my height, and then directed me to sit on the table and to remove my shirt. She took a blood pressure reading and told her findings to Dr. Davis. He said that was an extremely high pressure reading and questioned me about any history of high blood pressure. He took my blood pressure in both arms, and decided that it wasn't high after all. Next he took his stethoscope and listened to my chest and back. He concluded his examination by pressing around my stomach a couple of times and then he went back to his desk and started to write. I was still on the table when his assistant came over and drew two vials of blood.

Dr. Davis told me that I had a viral infection in my throat and ears and that he would prescribe some medication. He wanted me to have an ear test, an EKG, and a chest x-ray. I was also to come back at ten o'clock the next Friday to be examined by the ear, nose and throat specialist.

My visit to Morris Avenue ended after I had a diagnostic hearing exam, administered by an assistant. As per the allergy test, I was never told the result of this exam either.

The overall impression that was given by the staff of the clinic, and reinforced by the way that my examination was conducted, was that the facility was there strictly as a money making operation. If the patient care was good, that was merely a secondary aspect.

One of the other more flagrant examples of "Ping-ponging" came when I entered the Riis-Wald Clinic at Avenue D and asked to see a doctor. A receptionist took my Medicaid card, made three copies of it, and then asked me what was wrong. I told her that I had a burning feeling when I passed water. I was told that I would have to wait to see a medical doctor, but that there was a podiatrist and a chiropractor that were available immediately. I declined to see the podiatrist, because I still had some dye on my foot from a previous visit with a podiatrist. She persisted, and said that since this was my first visit, I should have a complete physical which included seeing all the physicians that were available. Again I declined and she continued to press, stressing the need for a complete case history, which could only be built by seeing all of the physicians. Finally, I conceded that maybe at a later date, I would see the podiatrist. I agreed to see the chiropractor that day.

Dr. Diniz, the chiropractor, was the first practitioner that I saw. He asked me many of the general medical history questions that are usually asked by the physician. He pressed on my spine and massaged my muscles. He told me that I should return in one week, because that was when a specialist would be in, and then I could get a thorough examination. He indicated that an x-ray examination would be necessary, since "sometimes you may appear to be healthy on the outside, but full body x-rays are necessary to get a picture of what is going on in your bones." After he finished his examination and made another appointment for me, I was ushered back into the waiting room.

After about fifteen minutes, a woman in white came into the waiting room and took me back to the examining room. She asked for a complete rundown on any medical disorders that were in my family. She took my temperature and asked me what the reason was that I had come to the clinic. Shortly thereafter, Dr. Ortez entered the examining room and gave me a superficial examination. He, too, asked me what the problem was and again I repeated it. Then he asked me when I last had sex, so I assumed that he was thinking that it might be some kind of veneral disease. Then he took a swab for a culture.

Even though I complained of a burning sensation when I urinated, he did not request a urine sample. My visit with the doctor lasted approximately ten minutes.

He gave me a prescription for an antibiotic, instructed me on how to take it, and told me to return in about a week for the results of the swab test.

Upon entering the East Harlem Medical Group I was directed upstairs by the receptionist for the dentist, when I asked to see a medical doctor. My doubts about this office began when I had to ascend a flight of rickety and worn, dirty stairs.

Untouched During Examination

When I entered the dirty cramped waiting room I asked to see a doctor. The receptionist took my Medicaid card and made copies of it. She then made out a folder for me and told me to have a seat. After waiting for a while, I was seen by a Dr. Clyde H. Weissbart. Dr. Weissbart asked me why I was there, and I told him that I was depressed, I didn't feel well, and I couldn't sleep well at night. I requested to be given something to help me sleep at night and something to help curb my appetite. Dr. Weissbart gave me a very brief examination. It consisted of his sitting in his chair and asking me if I had had pneumonia recently, been in the hospital or had any other serious ailments. I answered no to all these questions. (The closest he came to me was when I stood on a scale and he took my weight. He did not touch me during the course of the entire examination.)

He then told me that he could see that I was depressed and something was bothering me. He directed me to return the next day to see the psychiatrist. He prescribed medication for me in the meantime. In addition, he directed his assistants to give me an x-ray and to draw blood from me. I also gave a urine sample. Dr. Weissbart then asked me "Do you know where the pharmacies are in the area?" I said, "No, I don't." He said," "There's one across the street on both corners, and there is one downstairs. It might be easier for you to fill these prescriptions downstairs." Dr. Weissbart then asked if I were having any trouble with my feet. I said no, not that I knew of. Nevertheless, he suggested that I see the podiatrist for a routine examination.

After a wait I was examined very briefly by a Dr. Napoil. He told me to take off my shoes. He looked at the tops and bottom of my feet, but not between my toes; had he looked he might have discovered that I had a mild case of athlete's foot. After looking at my feet he decided I had a bunion on my right foot. This is the reason he ordered x-rays of both feet. I was later instructed to return in a week for further examination and to get results of today's testing.

On the following day, I went to the Family Health Professional Office at 2369 Second Avenue, New York. At this center, I saw a podiatrist named Luckower. Dr. Luckower examined my feet and told me he thought I had the beginnings of a bunion on my left foot. He told me the great toe of my left foot was pushing too far to the left. He too took an x-ray of my feet. His method of x-raying was unique of all the x-rays I have had. Dr. Luckower directed me to put my feet on a large yellow envelope while he positioned what appeared to be a dental x-ray machine above my feet. He then took the cord attached to the machine and stepped back into the hallway and operated the x-ray machine from there.

In conclusion, I must say I found it astonishing that Dr. Napoli could think I might have a bunion on my right foot and Dr. Luckower believe the same condition existed on the opposite foot.

Senator Moss. Thank you, Jimmy. Very good.

Mr. Halamandaris. Mr. Chairman, we are very pleased to have Catherine Hawes, an investigator of the Committee on Aging. Miss Hawes has done a lot of research in the nursing field, and we were very fortunate to have her participate as an investigator and do some shopping for us.

Senator Moss. Thank you.

STATEMENT OF M. CATHERINE HAWES, INVESTIGATOR, COMMITTEE ON AGING

Miss Hawes. Good morning, Mr. Chairman and members of the Senate. I am Catherine Hawes. Starting on June 14, 1976, I began posing as a medicaid patient along with other members of the staff of the Committee on Aging.

Like Privates McDew and Roberts and Mrs. Oriol, I am troubled and offended by the conditions I discovered during this investigation of the health care available to the aged and others utilizing medicare and medicaid.

The practices described by Privates McDew and Roberts such as ping-ponging and overutilization of diagnostic tests are terrible drains on the public purse. I often wonder how many people are deprived of desperately needed services because Government funds are wasted by the kinds of medical practices we encountered in many clinics.

But if the waste of a few million dollars does not outrage you, then the destruction of the health of millions of aged and poor individuals should, for these clinics fail abysmally to provide even adequate health care to these people. We believe this failure is the most important issue.

It is our conclusion that 90 percent of the examinations we received are inadequate Our standard of comparison emerges not only from personal experience but also from discussion with professors of medicine and health sciences at George Washington University and at Georgetown University. We asked these medical men what we could reasonably expect by way of examinations for the various symptoms we presented. In the great majority of cases, the examinations we received were deficient in one or more respects. For example:

We have been given EKG's when the tapes were not marked and dated.

We had allergy tests that were not read.

We had TB Tine tests where the area was not circled—as is standard medical practice—nor were we told what reaction to watch for or what to do in case of a reaction.

We had EKG's taken with the electrodes placed over our stockings.

In many instances when a stethoscope was used, it was placed over our clothing.

We have seen used urine sample bottles returned to the shelf for use after thay have been rinsed only once with water.

We have seen clinics with only one thermometer.

In all the time we spent in medicaid mills we never had anything approaching an adequate medical history taken.

We rarely spent more than 4 minutes with any particular practitioner having a physical exam made.

We saw X-rays being given to us without plates in the machine. We had numerous X-rays given without changing plates, and we had chest and feet X-rays with dental X-ray equipment.

Quality of Care "Horrifying"

Clearly the magnitude of this mistreatment is astounding and horrifying. What is even sadder is the fact that the sloppy medical practice which causes such errors is commonplace in too many medic-

aid mills, as our own experience indicate. I found the quality of care provided to me as a medicaid patient in New York, New Jersey, and California to be horrendous.

My experience at 43 Avenue C Medical Group in the lower East Side of New York, though hardly isolated, is a classic case of such treatment. In some sense, the treatment here typifies every evil I found in the clinics I visited—ping-ponging, long waits in filthy, roach-infested waiting rooms, perfunctory physical examinations, sloppy medical practice and unneeded tests, prescriptions written to be filled at an affiliated pharmacy.

In this clinic I asked the receptionist for an appointment with a medical doctor, telling her that I had a cold. Yet she suggested that I also see the foot doctor and the eye doctor, too. I replied that really all I had was a cold, but she insisted, explaining that the medical doctor was busy and would be for a while. She said that I could see the others while I waited.

After 15 or 20 minutes I was directed to the podiatrist's office. He asked me what was wrong and I said that I had a cold. Despite this he told me to sit down, and he proceeded to examine my feet. He told me that I should come in monthly to have dead skin trimmed from my feet, offering the explanation that if I did it, I might cut too deeply and hurt myself.

He inadvertently demonstrated this danger by then slicing quite deeply into my toe. Hastily, he slapped on a bandage without even applying any antiseptic. I assume he was hoping that I wouldn't notice the damage, but the toe bled on and off for 3 days.

He was about to do some more unnecessary carving on my feet, but realizing this I told him I thought I was going to throw up. He immediately said my feet were fine and quickly sent me back to the waiting room. All of this took no more than 3 minutes.

After a long wait while watching roaches wander leisurely around the room, I was shown back to the office of the medical practitioner. He asked what my problem was and I responded again that I thought I had a cold. He told me to sit on an examining table and took my blood pressure over my rolled up sleeve, then listened to my breathing and heart with his stethoscope just under my collarbone and on my back over my shirt and T-shirt. He asked no questions about mine or my family's history but did ask if I was allergic to any medications. Then he wrote out two prescriptions, without offering any explanation or instructions on their usage. During the 3 minutes I was with him in his office I don't think he ever really looked at me or considered me as an individual. I honestly felt like a siphon, a nonentity.

Eye Examiner Not Qualified

I fared no better during the cursory exam I received from a person I presumed to be the "eye doctor." Although he did seem to use the proper equipment, he took only 3 or 4 minutes to arrive at the prescription for glasses. Thus when he wanted to do a glaucoma test which, according to him, required that he put anesthetic drops in my eyes, I refused.

He insisted that I had to have the test, trying to convince me by stating that his examination had disclosed that I had "deep cups," a condition of the optic nerve which is frequently a symptom of glau-

coma. He was quite forceful in his insistence that I had to have this test, implying that I was being ignorant and childish to refuse. I told him that I didn't have to do anything, so he reluctantly agreed to let me off without the drops and test but scheduled me for an appointment a few days later with the optometrist. This was the first time I knew that the man examining my eyes was not the real "eye doctor."

Thus I had entered Avenue C Medical Group complaining of a cold I did not really have. I not only got treated and received prescriptions for this nonexistent illness, I also came out with a prescription for glasses and foot powder—outgrowths of medical treatment I did not request and did not want. To make matters worse, my foot now actually did need medical attention and I was afraid that I might have a serious eye disease. In short, I came out of this medical facility in much worse condition than I entered it.

I, however, am fortunate enough to have good alternative medical care available. I was able to go to my regular ophthalmologist 2 weeks later and find that, like most nearsighted individuals who do not have glaucoma, I have shallow cups, not deep ones.

I kept thinking to myself—suppose that like most of the other patients we encountered during our investigation, we were dependent for care on clinics like these. For instance, our other investigators received equally serious middiagnoses, ranging from heart murmurs, hypertension and chest spasms, to kidney and bladder infections. Then we, too, could have been subjected to costly and plainful mistreatment. I remember this every time I think of a woman I met in a New Jersey clinic who had been told she had a lump in her breast.

Unfortunately, in terms of the quality of medical care, the clinics in New Jersey and California provided no evidence to me of markedly better care. At the Inter-Med Clinic in Los Angeles, I received what seemed to me to be the most thorough physical examination I had had in all of the clinics, yet the doctor prescribed medication for a sore throat I did not have. In addition, the nurse recorded my height as 2 inches shorter than it actually is, and she replaced on the shelf an unsterile urine sample bottle.

Yet the worst thing I saw in terms of quality of care occurred in a clinic in Brooklyn when a woman rushed into the clinic holding a little boy in her arms. His foot was cut and bleeding profusely, yet the receptionist told her that the doctor was busy and would not see her son for an hour. In fact, the doctor had spent much of the last hour in conference with a well-dressed man who was not a patient.

Clinics Only Available Medical Care

I think about what it would have been like if I had been that woman and if the boy had been my child—if I had been unable to get desperately needed health care. The point is, as investigators, we could leave those places. But for people who live in those areas, what we received in the weeks of our investigation is, for practical purposes, all they have available for everyday medical care.

Even all I have said, however, can't convey what it's like in these clinics, what it's like to get medical treatment in conditions so unsterile

that roaches roam the floors freely, to know that what the majority of medicaid facilities I visited provide is costly billing for the Government and callous care for the sick, poor of this Nation.

[The prepared statement of Miss Hawes follows:]

PREPARED STATEMENT OF CATHERINE HAWES

Mr. Chairman, Members of the Senate, my name is Catherine Hawes, and I am currently employed as an investigator for the United States Senate Subcommittee on Long-Term Care of the Special Committee on Aging. Under the auspices of the Committee, I was involved in an evaluation of the health care available to the aged and others dependent on Medicare and Medicaid. Like Privates McDew and Roberts and Mrs. Oriol, I am troubled and offended by the conditions I discovered during this investigation.

The practices we encountered such as "ping-ponging" of patients from one clinic physician to another and the overutilization of diagnostic tests are terrible drains on the public purse. The waste of tax money engendered by this kind of fraud and abuse, of necessity, limits the funds available for other public programs. I often wonder how many other people are deprived of desperately needed services because government funds are wasted by the kinds of medical practices we encountered in many clinics.

But if the waste of a few million dollars does not outrage you, then the destruction of the health of millions of aged and poor people should, for these clinics fail abysmally to provide even adequate health care to these individuals. I found the quality of care provided to me as a Medicaid patient in these clinics to be horrendous.

In some sense Avenue C Medical Group in the Lower East Side of New York typifies everything I found wrong with the health care available to the elderly poor and other medically indigent individuals in this country—ping-ponging of patients from one doctor in the clinic to another, long waits in filthy, roach-infested waiting rooms, perfunctory physical examinations, sloppy medical practice and unneeded tests, prescriptions written to be filled at an affiliated pharmacy.

In this clinic I asked the receptionist for an appointment with a medical doctor, telling her that I had a cold. Yet she immediately suggested that I see the foot doctor and the eye doctor, too. I replied that really all I had was a cold, but she insisted, explaining that the medical doctor was busy and would be for a while. She said that I could see the others while I waited.

After 15 or 20 minutes, I was directed to the podiatrist's office. He asked me what was wrong, and I said that I had a cold and had come to see the medical doctor. Despite this, he told me to sit down and proceeded to examine my feet. Then he told me that I should come in to see him monthly to have the dead skin trimmed from my feet, offering the explanation that I might cut too deeply into a callous and hurt myself—something he inadvertently demonstrated by slicing quite deeply into my toe. He hastily slapped on a bandage without ever applying any antiseptic. I assume he was hoping I wouldn't notice the damage, but the toe bled on and off for three days after I removed his bandage. He also stated that I seemed to have a problem with excessively sweaty feet—something even my best friends and worst enemies have never suggested—and wrote out a prescription for a foot powder and fungicide. He was about to do some more unnecessary carving on my feet, but realizing this I told him I felt sick to my stomach. He immediately said my feet were fine and sent me back to the waiting room. All of this took no more than three minutes.

After a long wait while watching roaches wander leisurely around the room—I was shown back to the office of the medical practitioner. He asked what my problem was, and I responded that I thought I had a cold. He told me to sit on an examining table and took my blood pressure over my rolled-up sleeve, then listened to my breathing and heart with his stethoscope on my collar bone and on my back over my shirt. He asked no questions about mine or my family's medical history but did ask if I was allergic to any medications, and then he wrote out two prescriptions. During the three minutes I was with him in his office, I don't think he ever really looked at me or considered me as an individual. I honestly felt like a cipher, a nonentity.

MONEY, NOT CARE, IS MAJOR CONCERN

Again I was sent back to the waiting room. As I sat there, I observed a heated argument between the receptionist and one of the clinic physicians, from all evidence, a foreign medical doctor. This doctor was complaining bitterly that the owner wasn't paying him quickly enough for the patients he treated. The receptionist pointed out that some of those patients were on Supplemental Security Income and that their bills hadn't yet been paid. Therefore, according to her, the doctor couldn't receive his percentage until the bills were paid. The doctor shouted that he didn't see why he should be working if he wasn't getting paid, complained about his hours, and stalked back down the hall. During this same time there was another shouting match in another of the clinic's halls. Someone was literally screaming about the $1000 a week he was paying and asking what his "one percent" was going for. Unfortunately for me, a child started crying during this last argument, and I was unable to hear the entire discussion.

But this kind of dissention among the doctors and the staff serve to highlight what I believe are their major concerns—how much money they can make rather than how much good medical service they can provide to the community. My belief in this was heightened by the cursory eye exam I received from a person I presumed to be the eye doctor. Although he did seem to use the proper equipment, he took only 3 or 4 minutes to arrive at the prescription for my glasses. Thus, when he wanted to do a glaucoma test which, according to him, required that he put anesthetic drops in my eyes, I refused. He insisted that I had to have the test, trying to convince me by stating that his examination had disclosed that I had "deep cups," a condition of the optic nerve which is frequently a symptom of glaucoma. He was quite forceful in his insistence that I had to have this test, implying that I was being ignorant and childish to refuse. I told him that I didn't have to do anything, so he reluctantly agreed to let me off without the drops and test and scheduled me for an appointment a few days later with the eye doctor. This was the first time I knew that the man examining me was not the real eye doctor.

Thus I entered Avenue C Medical complaining of a cold I did not have. I not only got treated and received prescriptions for this non-existent illness, I also emerged with a prescription for glasses and for foot powder—outgrowths of medical treatment I did not request and did not want. To make matters worse, my foot now actually did need medical attention, and I was afraid that I might have a serious eye disease. In short, I came out of this medical facility in much worse condition than I entered it.

I, however, am fortunate enough to have good alternative medical care available. I was able to go to my regular ophthamologist two weeks later and find that, like most nearsighted individuals who do not have glaucoma, I have shallow cups, not deep ones.

I keep asking myself—suppose that like of the other patients we encountered during this investigation, we were dependent for care on clinics like these. Our other investigators, for instance, received equally serious misdiagnoses, ranging from heart murmurs, hypertension, and chest spasms, to kidney and bladder infections. Then we too could have been involved in costly and painful mistreatment.

While this treatment at the 43 Avenue C Medical Group typifies the evils I witnessed, it is not alone. At Midwood Medical Center in Brooklyn, for instance, I received archetypical treatment—a long wait in a grimy waiting room in order to have a medical practitioner spend only 1½ to 2 minutes on a physical examination. Actually I was amazed at his speed—in that time he used a stethoscope to listen to my breathing, glanced into my ears, nose and throat, using a flashlight, and placed the back of his hand against my forehead to see if I had a fever. Then offering no explanation or instruction on proper usage, he wrote out his prescription for medication and dismissed me.

Of course, occasionally a doctor would spend more than two minutes with me. At Grand Humboldt Medical Center in Brooklyn, a doctor spent nearly 15 minutes with me, some of it on the physical exam but most of it asking me about my problems in raising children in this area of the city. While he seemed nice and concerned about me as an individual patient, he could afford to be leisurely with me since I was the only patient in the clinic, aside from investigator Darrell McDew. Actually I began to wish that I hadn't received quite so much personal attention from the doctor. After he put a tourniquet around my arm in preparation for drawing a blood sample, the doctor then spent so much time waiting for the nurse to bring a disposable syringe, that my entire lower arm temporarily

lost all feeling. Here too, as at most of the clinics I visited in New York and New Jersey, some member of the medical staff of the clinic directed me to have my prescriptions filled at a specified pharmacy.

AVERAGE EXAMINATION, 3 MINUTES

People's Medical Center in Brooklyn presented a fairly typical physical setting for the clinics I visited in New York, except that it was incredibly crowded. When I arrived around 11:30 a.m., there were already 12 or 13 people in the waiting room, and by the time I got "treated," almost two hours later, there were at least 25 adults and 10 to 15 children sitting and standing in the waiting room and on the sidewalk outside the entrance. No doctors were in the clinic until 1:00 when the podiatrist arrived. The gynecologist and internist were in attendance by 1:30. The line in the waiting room was quickly reduced in as much as the internist spent less than 3 minutes with each of his patients, including the Medicare recipient who preceded me, an elderly black man with a baseball-sized tumor on his head.

The internist took about the same amount of time with me, spending most of it filling out a second billing form. The only things he did which even approached a physical examination were to look in my throat with a pencil flashlight and listen to my breathing with his stethoscope placed outside my shirt and T-shirt. He did take the time to prescribe Valium for me when I replied "Yes" to his question, "Do you ever get nervous?" He also took the time to "ping-pong" me to the podiatrist when I asked him for a band-aid for a blister on my heel, after seeing a box of band-aids on his desk. He told me that he couldn't do anything for my feet—that I'd have to see the podiatrist. I repeated that I only wanted a band-aid, but he insisted that I see the podiatrist for it. He also ordered a blood test for me.

One of the unhappy aspects of treatment in these clinics is the rough manner of the clinic personnel. For instance, when the nurse came to draw the blood sample, we had a slight argument over which arm she would draw it from. I insisted that she take it from my left arm, since I knew I had a bruise on my right arm from a sample taken at another clinic. Finally she took the blood from my left arm. By the following day, I had bruises on both arms, just another indicator of sloppy health practice.

The podiatrist, whom I saw next, was a very friendly man, who chatted with me about what good feet I have while he trimmed some dead skin off the bottoms of my feet. I asked him not to do that, since I had to walk quite a bit more that day and stating again that all I came in for was a band-aid. He assured me that his trimming wouldn't make my feet tender at all—which turned out to be false. Walking was painful for at least 2 days. He assured me that he would "fix (my) feet right up," and then he clipped two toe-nails on my left foot. After that he said that I would have no more pain from the "turned-in" nail, as he called it. I replied that I never had had any pain or discomfort from it, and he responded, "Well, you certainly won't have any trouble with it now."

While still telling me that I had good feet and saying that "we should just make sure," he slid an 8½'' by 11'' manilla folder with "KODAK" printed on it under my feet and pulled what appeared to be a Ritter dental x-ray machine down over my feet. He then moved to the corner of the room—approximately 8 feet away—and pressed a button at the end of a long cord. After putting another KODAK folder under my feet and turning my feet slightly so they rested on their sides, he repeated the procedure. But the podiatrist also took an interest in other aspects of my health. He suggested that I see the clinic's gynecologist. He even went out to the desk and made an appointment for me, and he recommended the clinic's pediatrician to me for my children. All of this I got for the complaint of a common cold which I didn't have.

I found the situation in New Jersey Medicaid facilities to be much the same as in New York. At Park Medico Center in Paterson, for instance, the doctor listened to my breathing and heart and took my blood pressure over my clothing. As a matter of fact, during the entire investigation, I was never directed to remove any article of clothing other than my shoes and socks. Most of the time, the doctors would take blood pressure and place their stethoscopes over clothing. Occasionally they would pull my shirt to the side or up in back to place their stethoscopes properly, but in general, their main concern seemed to be to get the billing form filled out and to get rid of me as a patient quickly, expending the least amount of effort and time as possible.

It's hard to realize now just how horrible the filth in those clinics is, but I was particularly struck with this realization during one weekend. I had returned

to my home here in Washington and on Sunday afternoon was in a laundromat. A woman who worked there was sweeping the floor. With a start I realized that the floor of this laundromat—even before she swept it—was cleaner than any medical clinic I'd visited for treatment in the previous two weeks.

PATIENTS DEPRIVED OF PRIVACY

The Broad Street Medical Clinic in Newark, New Jersey, is another classic of its kind. I entered the clinic complaining of a sore throat. After half an hour in the waiting room. I was called by the nurse into an examining room. An elderly black woman was still in the examining room and despite my presence, the nurse proceeded to discuss details of the woman's treatment with her and to belittle her ability to follow the doctor's instructions. The nurse exhibited a noticeable impatience with the woman and with her questions about her medical condition, displaying an attitude I found extremely objectionable even to observe. But the elderly patient evidently found this to be standard treatment, in as much as she exhibited no surprise at being so addressed in front of a stranger or at being deprived of privacy.

After that patient was dismissed, the nurse turned to me and proceeded to ask questions about my medical history and to weigh me, measure my height, and take my temperature. She also extolled the virtues of this clinic and of being treated by "specialists," assuring me that they could take care of all my health needs. The nurse asked me when I had had my last Pap Smear. Fearing any contact with a gynecologist in this clinic, I answered that it had been just two months. Nevertheless, the nurse asserted that I should really have another and signed me up for an unsolicited appointment with the clinic's gynecologist. The nurse then asked if I had any trouble with my skin. I said I didn't, but she persisted, and I admitted that I do have some wrinkles. Peering at me she replied, "Yes, I can see that," mumbled something about "those blemishes" and said I should see the clinic's dermatologist. Again she made an appointment for me. At this point, I wanted to rush to a mirror to see if I'd suddenly developed a horrible case of acne; but before I could leave, the nurse suggested that I see the clinic's podiatrist to have my feet taken care of, despite my assertion that I had no problem. After this—but before I had seen *any* physician—the nurse scheduled me for blood and urine tests and for chest x-rays, despite my pleas that I really didn't have enough time for all of that today and promised that I would have those tests when I returned for my other appointments. My unwillingness had no effect, however, on the nurse. It was at this same clinic that this nurse in the presence of the doctor, told me that he could prescribe some pills for me that would "make a new woman" of me. She noted that unfortunately Medicaid would not pay for such pills, but she suggested that I give up smoking and use the money saved to buy the pills. I hastily replied that I had never smoked and thus couldn't save money by quitting and that I had no extra money for pills.

It was also at this clinic that I witnessed one of the incidents which has caused me the most sadness. While I was in the waiting room, I struck up an acquaintance with a woman and her child who were also waiting to see one of the clinic physicians. Because long waits were usual and reading material was rarely available in the clinics, I carried yarn with me. I was crocheting while I waited, and the child wanted me to teach her how to crochet. While I did, her mother and I had a very pleasant conversation about children and family. Later, as I was sitting in the examining room, this woman walked by on the street outside and we waved at one another through the window. By way of extolling the virtues of the clinic doctors, the nurse said, "Oh, you know her? She has a lump in her breast, you know, and she's being treated by one of our specialists." I still remember that woman's gentle face and am horrified to think of her being dependent for diagnosis and treatment by people such as many of the ones we encountered on this investigation. I despair when thinking of what this woman and many like her must endure at the hands of those physicians who are more intent on profits than on care.

In my opinion, California differed in some respects from the picture of Medicaid mills in New York and New Jersey. For instance, in my investigation, I found no evidence of "ping-ponging of patients from one 'specialist'" in the clinic to another, but while Medi-Cal rules may have reduced or altered this kind of monetary fraud and abuse, I have no evidence that the program is providing better medical care than that found in the other State programs we investigated.

It was in San Francisco, for instance, at the Geary Street Medical Office, that

I went in complaining of a sore throat and was examined only by a nurse. I never even saw the doctor. However, it was also in California that I got what I personally feel was the most adequate exam.

At the Inter-Med Clinic in Los Angeles, I received what seemed to be the most thorough physical examination I had in all of the clinics I visited. Nevertheless, he prescribed medication for a sore throat I did not have. Furthermore, the nurse provided a glaring example of poor health practice.

SOAPY "URINE" SAMPLE "NORMAL"

It seemed sloppy enough that the nurse measured me and recorded my height as two inches shorter than it actually is, but then the nurse handed me a smudged urine sample bottle and directed me to the bathroom. Because the place itself was grimy and because it was my second and third exam of the day, I filled the urine cup with a mixture of water and green liquid soap I found in the bathroom. The nurse not only accepted this offering, she tested it with a dip stix and announced that the four colored tabs indicated no abnormality in my urine. I was really relieved that I hadn't actually used the urine cup as ordered, since the nurse emptied the contents into the sink and then merely ran water over the bottle, rinsing it out only once with water, before returning it to the shelf with the rest of the "clean" bottles, ready to be used again on some other unsuspecting patient.

Yet the worst thing I saw happened in a clinic in Brooklyn. Ten to twelve women and as many children crowded into the waiting room which was made grimier and noiser by the continual coming and going of workmen and their equipment into the space being added onto the clinic. Although the office roster listed six doctors, only one was on duty that morning, and he was seeing patients only sporadically, spending much of the first hour in the clinic in discussion with someone who appeared to be a drug and equipment salesman. Soon after the salesman's departure, a woman rushed into the clinic, holding a little boy in her arms. His foot was cut and bleeding profusely, and she was clearly upset as she asked the receptionist to see a doctor. But the receptionist said that it would be at least an hour before the doctor could see the child and suggested the woman go down the street to another clinic. She went out, still carrying the child, looking for help, but evidently she didn't get it at the other clinic either, because I saw her a few minutes later coming back down the street from the direction of the other clinic, and the boy was still untreated, still bleeding.

I keep thinking about what it would have been like if I had been that woman and if that had been my child—if I had been unable to get desperately needed health care. The point is, as investigators we could leave those places behind. But for the people in these areas, what we received in the weeks of our investigation is, for practical purposes, all they have available for everyday medical care. As a Medicare or Medicaid patient you can expect long waits in dirty waiting rooms and exams so cursory that the medical personnel don't even bother to have you remove your clothing when taking blood pressure or listening to your heart or breathing. You can expect bathrooms that would shame the worst service station you've ever been in, unsterilized urine sample cups and disposable syringes that aren't broken after being used to draw blood. You can expect blood tests to be given so clumsily that your arms are badly bruised, hardly ever having your arm swabbed before they jab the needle in, rarely being told why tests are being made and what the results are. You can expect to be treated in a demeaning manner by medical personnel who exhibit little regard for your right to be informed or for privacy. Many times I shared an examining room with another patient while one or both of us was subjected to tests or was having our medical history taken, and on at least one occasion, the other patient was male. Rarely are you told by the physician what his or her diagnosis is or what or how many bills he or she is submitting. In most clinics, outside California, the receptionist has photocopied your Medicaid card one or more times, and as a patient you have no responsibility or authority to review or sign the billing form. Even after you are told to go to what is probably an affiliated pharmacy—you are required to sign a blank billing form before your prescription is filled. Yet even all of this can't begin to convey what it's like in these clinics, what it's like to get medical treatment in conditions so unsterile that roaches roam the floors freely, to know that what the majority of Medicaid facilities I visited provide is costly billing for the government and callous care for the sick, poor of this Nation.

Senator Moss. Thank you very much for your good testimony.

Mr. HALAMANDARIS. At this point, Mr. Chairman, may we bring in the medications which the six healthy Senate investigators received in this brief period of time? These are the medications that we received while posing as patients. Keep in mind that the Senate investigators were perfectly healthy.

Senator MOSS. Are my prescriptions included in there?

Mr. HALAMANDARIS. Yes, sir. Some of the drugs are presently being analyzed by the Food and Drug Administration.

Senator PERCY. That is enough to kill all of us.

Senator BEALL. Was there an average cost associated with this?

PRESCRIPTIONS CHECKED BY FDA

Mr. HALAMANDARIS. We are trying to establish that, Senator Beall. As I indicated, the Food and Drug Administration is finding some substitutions, some illegal contraband. When the Food and Drug Administration is through, we will have some interesting results.

Senator MOSS. That is what I acquired in two visits.

Senator BEALL. You have not told us whether you were healthy before you went there.

Senator MOSS. I will defer that to Dr. Carey. He gave me a clean bill of health.

Senator PERCY. How have you been feeling since you came back?

Senator MOSS. Pretty lousy.

Senator BEALL. Is that one visit?

Senator MOSS. No; two clinics to get this, and all I complained of is I thought I had a cold.

Senator BEALL. What is it?

Senator MOSS. You can read on it. I cannot tell you what they are all for.

Senator PERCY. Family pharmacy.

Do you want to try some?

Senator BEALL. No; thank you.

Senator MOSS. Have a swig on me.

Well, I think the staff has made the point very dramatically.

None of the people that entered any of these clinics had any real medical problem, is that correct?

Mr. HALAMANDARIS. That is correct.

I would like to make a couple of points. The medications that are on the table obviously are all marked. This is going to be evidence in whatever criminal trials progress as a result of our investigation and findings that have been turned over to the U.S. attorneys in Michigan and New York.

The billings are just starting to come in. That is going to be the real story of this investigation in my judgment. I want to discuss that; I think I would like to take about 4 more minutes wrap up and clarify some remaining misconceptions.

Senator MOSS. Go ahead.

Mr. HALAMANDARIS. I would like to refer you to page 48 of the report, if I may. On that page there is yet another chart which we constructed after conferring with the U.S. attorney on the court records that he had dealings with eight medicaid clinics. As we indicate, the principals, two doctors, received $2,222,000 from the medicaid program. There is a breakdown where the money goes.

The first 12 percent off the top goes to the factoring firm, $10,000, and with a kickback it comes back to the principals—25 percent of the gross, of the roughly $2 million, is rent which is then paid to the principals. Then we have the remainder which is divided 50–50 between the owners of the clinics and the practitioners which also means that we are talking about another $700,000 which goes to the principals. To this amount you add in whatever amounts the principals received as kickbacks, and in this particular case they have a 30-percent kickback from the clinics which amounts to about $217,000. So the grand total that the two principals in these eight clinics made is about $1.5 million from the clinics that they owned out of the $2 million that the clinics received.

Businessmen Receive 70 Percent of Money

Now the point is this: This distribution of funds is a common industry practice among medicaid mills. The landowners take about 70 percent of the money that is paid to medicaid mills. Only 30 percent goes to the doctors who do the work. We think this is one of the most egregious practices we found.

The common industry practice is for the businessman, who essentially does nothing more than own the building or own the lease to receive roughly 70 percent of the money that flows through medicaid mills. We think there is something wrong with this. We don't think this is what the Congress had in mind when they appropriated medicaid funds.

How large is the problem of medicaid mills? Let's talk about national figures. Medicaid in 1975 was at the $15 billion level. Of this amount, roughly $3 billion was paid to physicians and dentists and chiropractors and podiatrists, pharmacies, and clinical laboratories.

We estimate that about $1 billion a year flows through medicaid mills. As much as 50 percent of this may be unnecessarily paid.

This has nothing to do with any estimates of fraud, it is simply our judgment that this is money that need not be paid. New York figures are more problematic because of the condition of the New York data. Nevertheless in New York the best we could find out, $3.2 billion to the medicaid program, about $320 million in New York State goes to dentists and physicians and pharmacists and clinical laboratories and approximately $240 million is our projection of the amount that goes to medicaid mills of the entire State, not to be confused in New York City. In short, about $168 million is paid to practitioners, medicaid mill entrepreneurs. Our estimate is that $112 million is paid out unnecessarily.

I would like to generalize a little bit more and summarize and say 90 percent of the care that we found was substandard, and I think Miss Hawes was very eloquent in giving the standards of comparison that we used. When you say that you have a cold and the doctor does not look down your throat, we think that is substandard care. When you say you have a cold and the doctor looks down your throat with a normal flashlight 5 feet away, we think that is inadequate care. When the doctor does not look at your ears, when he does not check your eyes, when he does not take your blood pressure, when he takes your blood pressure over your sleeve, when he tries to put a stethoscope on your chest and does not ask you to take your jacket off, we think there is

something wrong. It is our estimate that 90 percent of the care is substandard.

In approximately 70 percent of our visits we found some unnecessary testing going on. In about 45 percent of the cases we got a referral of some kind to another practitioner. About 25 percent of the time we encountered blatant ping-ponging or, that is to say, obvious overutilization. The exact figures for outright fraud as opposed to overutilization is difficult to compute at this point because we have only received about 40 billings back. However, we can make one statement with certainty. Every one of the 40 bills that has been received has justified payment to medicaid by indicating the diagnosis of some disease that we didn't have.

Again let me repeat that. Everyone of the some 40 statements or billings that have been presented to medicaid indicate as a justification for payment, a disease that none of us had.

Now there are more blatant cases. If you want to talk about the extreme cases, I'll tell you of my experience when I went into a medicaid mill on the Grand Concourse in the Bronx. I saw a general practitioner for 4 minutes. The billing that came back to the U.S. attorney indicated that I not only had seen the general practitioner but that I also saw a psychiatrist and podiatrist. Interestingly enough, this podiatrist also billed for seeing Officer McDew and Officer Roberts. In fact, the podiatrist didn't see any of the three of us.

You noticed in today's paper that the State Department of Social Services is calling in about a thousand doctors to discuss this problem, so we are delighted to see that action.

I would like to close by asking your consent, Mr. Chairman, to have entered in the record the New York Times article from August 12 which indicates that excess payments, overutilization, and ping-ponging were also found in so-called nonprofit clinics in New York as distinguished from the for-profit medicaid mills which were the subject of our investigation.

Senator Moss. Is that this year?

Mr. Halamandaris. Yes, sir. They estimated an $18 million loss and they project an overutilization as distinguished from the for-profit medicaid mills we visited.

Senator Moss. Without objection, that will be placed in the record at this point.

[The article follows:]

[From the New York Times, Aug. 12, 1976]

Excess Payments Found in Clinics

Medicaid Audit of Nonprofit Units in New York Puts Total at $18 Million

(By David Bird)

As much as $18 million in overpayments for Medicaid patients may have gone to private nonprofit clinics here last year, according to a preliminary audit released yesterday by the New York City Health Department.

The audit showed that as much as 12.8 percent of the $140 million paid in 1975 to the nonprofit clinics, including those in some of the most noted teaching hospitals in the city, might not have been justified.

Medicaid, which pays medical bills for the poor, is financed 50 percent by the Federal Government and 25 per cent each by the city and state.

PRACTICE FOUND WIDER

Previously the Health Department, with limited staff, had concentrated on auditing the private, profit-making so-called "Medicaid mills," where excessive and illegal Medicaid billing had been found.

Now the same pattern is being found, according to the Health Department, in the private nonprofit (voluntary) hospital clinics and other clinics operated by charitable organizations.

"Abuses such as overutilization of services, ping-ponging of patients and poor documentation of services, which previously had been thought to be exclusively a practice of 'Medicaid mills' have been documented in almost all voluntary hospitals and free standing clinics studied," said a statement from the Health Department.

Pingponging is the term applied to the practice of sending a patient from one specialist to another, whether he needs the attention or not, and collecting a fee for each visit.

So far, more than a dozen of the nonprofit institutions have been studied, according to Dr. Martin Paris, associate commissioner of health and executive medical director of Medicaid.

The sample covers a wide spectrum of the nonprofit institutions, from the smaller to the largest, Dr. Paris said, and is a strong indication of what is happening in the entire system.

Dr. Paris said that, as a result of the audit, Mount Sinai Hospital already had returned $67,000 for billing irregularities noted in its dental clinic.

MANY VISITS MADE

Dental clinics showed signficant abuses, according to the Health Department.

"We have seen cases of patients returning 40 and 50 times to a clinic for routine dental services, generating costs of over $2,000," said Dr. Thomas Travers, director of the Health Department's Division of Institutional Ambulatory Care. "In private practice, these services would require less than five visits and cost less than $300."

At Mount Sinai, Dr. S. David Pomrise, the executive vice president, issued the following reply to the audit:

"The services in question were performed by the dental clinic. The patients had been identified as Medicaid eligible but prior authorization, as required by Medicaid regulations, had not been received."

The Health Department said "Boys Club of New York Inc., which operates dental clinics has similarly refunded $11,000 for billing irregularities."

FRAUD IS DENIED

Anthony Siste, controller of Boy's Club which operates dental clinics in its clubhouse for 5,000 boys, said:

"No fraud was involved. One of our dental clerks just misinterpreted their regulations."

The Health Department said that lack of adequate controls, rather than the greed that motivated at least some Medicaid mills, apparently was the reason for excessive payments to nonprofit institutions.

"The outpatient clinics have always been considered the stepchild at hospitals, which are concerned primarily about inpatients," Dr. Paris said. "They don't care about the out-patient system, don't have administrative control systems and, since nobody's watching, the system goes wrong. Maybe it's not the same motivation as at the Medicaid mills, but the result is the same."

In addition to the dental audits, the Health Department has completed an audit of a wide range of ambulatory services at a sample of 12 voluntary institutions. It estimates that as much as $6.7 million of the $29 million in Medicaid bills from these institutions are questionable.

The institutions are: Long Island College Hospital, Bronx Lebanon Hospital, Methodist Hospital of Brooklyn, Misericordia Hospital, Unity Hospital, Lyndon Baines Johnson Family Health Center, St. Luke's Hospital, Maimonides Hospital, Long Island Jewish-Hillside Medical Center, Hospital for Joint Diseases, Arthur C. Logan Memorial Hospital and St. John's Episcopal Hospital.

COOPERATION CITED

Dr. Paris praised the involved institutions and the Greater New York Hospital Association for their cooperation in the investigation.

For its part, the association expressed confidence through its executive vice president, Dr. John V. Connorton, that the Health Department's statements "will prove to have grossly overstated the problem."

Some of the abuses charged by the Health Department included double-billing where doctors services were charged for twice, billing for appointments that patients did not keep and multiple billing for different clinic visits on the same day, violation of the law allowing only one clinic bill per patient in one day.

Of the more than $420 million paid for outpatient care for Medicaid patients here last year, about $120 million went to private practitioners, $140 to nonprofit organizations and $160 to municipal hospital clinics and emergency rooms.

Mr. HALAMANDARIS. In short, Mr. Chairman, on the basis of this examination into medicaid mills and on the basis of our examination into nursing homes and clinical laboratories, we are concluding that, there is massive fraud in the program. A conservative estimate would be 10 percent of the total. If it is $15 billion total, then we estimate that approximately $1.5 billion of the $15 billion is ripped off and the figure could be as high as 12 or 15 percent. These are only ball park estimates and I think we will know a lot better when the Department of Health, Education, and Welfare complete their investigation in a number of States.

I thank you very much for your attention. We appreciate the opportunity to work with all of you; it is a pleasure.

Senator Moss. Well, as I said in the beginning, the whole investigation carried on over such a long period of time has been remarkably well handled and you are to be commended for your direction on all of these people and others who participated certainly are to be commended for their sensitive attention to the very difficult job. I had only 1 day and I had enough people around me that I guess I should not have felt apprehensive at all but I did feel apprehensive at going into those clinics and I was pleased to have people along who had been through it before and therefore bolstered me.

Mr. HALAMANDARIS. I guess that is the point. When we were describing what we saw to you, I remember the look of shock and disbelief on your face when we first told you what we had found. You have to experience it yourself to realize what it is like, otherwise it is like trying to describe red to a blind man. I am glad that you went through it, Mr. Chairman, so that you could talk about it.

Senator Moss. Thank you.

Has New York begun any kind of program to remedy some of these glaring oversights in the supervision and detection of fraud?

SPECIAL PROSECUTOR FOR NURSING HOMES

Mr. HALAMANDARIS. Yes, sir, Mr. Chairman. It is a pleasure to know that Governor Carey has taken a number of initiatives, one of them being an appointment of a special prosecutor for nursing homes. Recently, at your request, he has given him authority to look into boarding homes and now is considering giving him jurisdiction over medicaid mills. That is one step.

The second step relates to funding by the legislature. At Governor Carey's request, the medicaid management and information system,

which they estmiate in New York will save $160 million, was funded. As you know, the New York Times today said the department of social services has cracked down on physicians; we are delighted to see their action.

Senator Beall. On that point, do I gather that even though the States, including New York, pay about 50 percent of the cost of medicaid and they have had to cut back on the services because of a lack of funds, it is just now that we are taking steps to police the program?

Mr. Halamandaris. Well, actually, sir, the initiative started in January 1975. Governor Carey came into office at the same time that a major nursing home investigation was underway.

Senator Beall. But they had no ongoing oversight connected with this program in their department of social services?

Mr. Halamandaris. Yes, sir, that is correct. It is my impression that there is a man named Dr. Martin Paris in the city who has been working very hard on the medicaid abuse, but he has only been in his position now for about 3 or 4 months and I think he would like to do a lot more. We should say that there were efforts promulgated by the city regulating medicaid mills, but their regulations were essentially shot down by vested interests. I think it is important to bring that out. Some people have been trying to do the job.

Senator Beall. Another question comes to mind that is very disturbing. All of these services are being rendered by licensed physicians, what steps, if any, have been taken by the licensing authorities in the State or by the professional groups in the State to police their own people? Obviously there is unscrupulous activity taking place from what you said here today.

Mr. Halamandaris. That is correct, Senator. We wrote to the professional societies. It is interesting to note that Senator Moss received notice that the State board of education is issuing regulations effective tomorrow, August 31, which would bar the percentage leases we are talking about. Thus it will be illegal to hire a doctor on commission, allowing him to keep 30 percent of the money he is paid with the entrepreneur keeping 70 percent.

Senator Beall. How about the State medical society?

Mr. Halamandaris. They have done precious little, to be frank.

Senator Beall. How about the PSRO's? Are the PSRO's doing anything?

Associations and Societies "Inactive"

Mr. Halamandaris. They are concerned with the quality of service offered by institutional providers and not necessarily with fraud. So they are not involved basically.

Senator Beall. But this is the delivery of care.

Mr. Halamandaris. I would agree. I would be in favor of giving them the authority to enable them to jump in and take hold of this problem but there has been no action to date.

Senator Beall. The professional associations and societies have been very inactive in this whole thing.

Mr. Halamandaris. With one exception and that is in Illinois. The Illinois Medical Society and the Illinois Physicians Union came to us and gave us the original evidence that we had on medicaid mills. Mr. Roger White and his colleagues told us essentially everything that we have reported to you today.

Senator Moss. The Senator from Illinois.

Senator Percy. I think we probably all ought to note for the record that, whereas we pointed out briefly that the nursing homes should always try to put it back in perspective, the whole system has not gone rotten just because of a few bad apples in the barrel and for every single abuse that we point out there are a dozen that are honorable and carry on their work in a fine way.

Since 1969, while looking into medicaid fraud and abuse, we have pointed out nursing home operators, pharmacists, medical laboratories, medicaid administrators, vendors, physicians, dentists. Is there any group that touches this program that has not in some way been implicated in fraud and abuse?

Mr. Halamandaris. I would like to come in the back door on the question and refer people to page 204 of the report. One thing we found which was most interesting was looking at the number of audits in the medicaid area conducted by the HEW audit agency. We found that the HEW audit agency has conducted 264 audits. You will note that an audit generally can deal with one or more audit areas. There is a total of 12 areas so there have been about 264 audits issued and 740 areas audited.

As noted in the italic type, 3 percent related to hospitals. If there is any area of the medicaid field that has not been investigated to any extent, it is hospitals. Neither this committee and not any other that I know of have investigated hospital fraud. It is my feeling that when we begin to do so we are going to find the same sort of abuses. I believe the entire medicaid system is faulty.

Senator Percy. When we have gone into other fields where there has been abuse, generally there is a trade association or some group that pulls them together that has some degree of responsibility, particularly in the professional field. In investigating hearing aid problems we went into the hearing aid industry and their association and asked for their assistance and help.

Responsibility Needed in Medical Profession

We have found abuse in New York and Chicago involving the medical profession. What is the position of the American medical profession in this regard? Do they accept the degree of responsibility? Do they feel that this is a blight on their house that they themselves must somehow deal with and can't leave everything to the Government to handle? You have got to have some need within the industry so that we get after this rather than through Government investigation.

Mr. Halamandaris. I would agree. It is refreshing to note that the American Medical Association has a canon which makes professional leasing unethical. They have no power to enforce the standard but their position is on the record. As Senator Domenici pointed out, they are in the rather peculiar position that most of the physicians that work in medicaid mills are foreign trained that essentially work on commission. The money is not going to the physicians; it is going to the entrepreneurs that own the clinics. You will find in our report in appendix A a list of doctors making over $100,000 from the medicaid program but when you trace it back you find out that these people

are merely conduits and the money is going into the hands of the businessmen.

Senator PERCY. Can you give us any further, specific examples of how medicaid fraud and abuse activities have grown in scale and in sophistication or has your testimony been pretty comprehensive?

Mr. HALAMANDARIS. I think the problem of fraud is pretty pervasive, Senator. Senator Moss has a memorandum which indicates not only the investigations we have done, but those we just have not been able to follow up on. For example, in the area of home health care we found substantial amounts of fraud, particularly among for-profit providers. The memorandum indicates a substantial amount of fraud continues among the clinical laboratories we have investigated.

The chairman has a GAO audit of 30 nursing homes which indicates every single one of them had problems associated with the handling of patients' funds. The problem is massive.

Senator PERCY. Have you heard of medicaid mills in States other than New York and Illinois? Do they exist in other States?

Mr. HALAMANDARIS. Yes, sir, they do. Let's analyze the list of high volume doctors and you can see exactly where they are. If you refer to the State of Texas, you are going to find that most of them are in San Antonio. If you refer to the State of California, you trace the addresses as we did and you find most of the high volume providers have mills in Los Angeles. High volume providers in Michigan as we indicated also practice out of Detroit medicaid mills. It's a general pattern.

Senator PERCY. We discovered that nursing homes became a new growth industry and you can buy stock in them on Wall Street. Is this a new growth industry that is springing up?

Mr. HALAMANDARIS. I think so.

Senator PERCY. Medicare mills.

Have you found medicare mills also?

MEDICARE MILLS IN FLORIDA

Mr. HALAMANDARIS. Yes, sir. I think the problem is just beginning. As you know, we did find medicare mills in Florida. In fact, one of the gentlemen that we interviewed in the course of pretending that we were businessmen from Chicago wanting to buy medicaid mills indicated that he had six or eight of them in Florida. Florida is one State that has a very low medicaid commitment. However, they have a substantial number of medicare beneficiaries down there. He said, "We play the same game in Florida but we don't call it medicaid down there, we call it medicare." He said, "There is no dental business down there but we do a hell of a lot of EKG's."

Senator PERCY. Will you describe how you actually went about setting up a dummy corporation to purchase medicaid mills?

Mr. HALAMANDARIS. It is not very difficult. Some of our investigators cooperated. We simply incorporated in the State of Delaware and paid our $44. I would like not to disclose the name of the corporation. We listed the purpose of the corporation: the buying and selling of health care facilities. It was just a precaution in case somebody checked us out. An answering service was hired in Chicago and we had a post office box, all by way of providing us with a cover.

Senator PERCY. Did you contact, during the course of the investigation, officials of the State and local officials in Illinois, New York, Michigan, and California and ask for their assistance and help. What degree of cooperation did you get from them?

Mr. HALAMANDARIS. We received great cooperation. In New York we also worked with Mr. Charles Hynes, special prosecutor for nursing homes. We worked with George Wilson, assistant U.S. attorney who advised us every step of the way. We worked very closely with the Special Commission on Investigation in New Jersey, the Michigan Fraud Squad, and in California our contact was the Joint Legislative Audit Committee and they have received our results. We wanted some criminal prosecutions to result from this rather than just putting on a show. Our main purpose however is legislation.

Senator PERCY. Mr. Chairman, I join with you in commending our staff who were temporarily assigned to this work. I don't think anyone can sit in this room and not have a feeling that you have an absolute necessity to find ways to correct this problem. You cannot go through what you just did, Ted, and not have a feeling that something has to be done.

Now the bottom line is where we go from here. We are not a legislative committee or subcommittee and it is for this reason that some time ago I contacted the Finance Committee, wrote them officially, asked them if they would undertake this burden of responsibility and I suggested that they go right to the State of Illinois, my own State, and investigate the situation that we simply knew ourselves required a legislative remedy.

S. 3205 has been introduced. Senator Moss and myself are cosponsors of that bill and I know it is going to have the full support and backing of Senator Beall. I would like to just pick a few things out of that as typical of the kinds of things we are going after and ask you for your appraisal as to whether or not these changes of the Finance Committee in this legislation would be of assistance and help to us.

BILL CONSOLIDATES FINANCING

First of all it seemed to me we did have a proliferation of departments and agencies within HEW and the bill combined the medicare and medicaid office of nursing home affairs and the bureau of quality assurance agencies into a single administration for health care financing. That consolidation focused the intention right into one area where there is no place they can pass the buck, and you are responsible for that. Would that organization help in HEW?

Mr. HALAMANDARIS. It is my feeling that it would, Senator. There are other provisions that I liked even better, that is the creation of the Office of Inspector General.

Senator PERCY. Now we have, I am sure, representatives of HEW sitting in the room and they have a degree of devotion to their job as we have to ours. I make my observation, excluding the Secretary, who is a very pragmatic and very hard hitting fellow, and I think he has been shocked at some of this. There is a naivete in HEW that really is almost rampant. They feel, well it is almost an attitude, that no one would ever dare defraud them in the fields of health, education, and welfare.

When Senator Nunn and I tried to discover why there was $1 billion defaulted on student loans, they had an investigator that came to the school and found there was a man who had declared himself dead so his wife would not be able to find him, and he is running a school dealing with very large sums of Federal funds. He just wanted to make money, he was not interested in education. There was money to be made in education and he made it.

I think HEW must reconize they have a tremendous internal responsibility. It is far too late when we get into the job or when U.S. attorneys do. By then the crime has been committed. So this legislation that we are proposing and Senator Talmadge is offering would create an essential fraud and abuse unit right within an agency. Now would that help?

Mr. Halamandaris. It is my feeling that it would, sir, particularly if the agency is headed by an Inspector General. We have been discussing these problems informally on a staff level. We have come to the agreement that the Talmadge bill would solve many of the problems we face.

Senator Percy. Mr. Halamandaris, would you assume that an agency that spends 1 out of 4 of our Federal dollars should have an Inspector General?

Mr. Halamandaris. Absolutely.

Senator Percy. Are you rather shocked that they don't have an Inspector General?

Mr. Halamandaris. I am, sir. I am shocked that the Senate has passed the bill two or three times but the House has never acted.

Senator Percy. Under the provisions of this bill, S. 3205, the Inspector General then would take over the direction of an essential fraud and abuse unit and also the general counsel of HEW would be authorized to prosecute directly civil fraud cases where U.S. attorneys have not acted in a timely fashion. Do you think that will help?

Mr. Halamandaris. Absolutely.

Senator Percy. Give them some of the clout to followup the sense of responsibility that they should have. They are the ones that are responsible for seeing that it is spent without fraud.

Sampling Finds 15 Percent Fraud

Mr. Halamandaris. Yes, absolutely. I add one word from Dr. Keith Weikel who is sensitized to this issue. As he reported to the Finance Committee last Thursday, they were finding about 15 percent fraud in their sampling in New York State which makes our estimates of 8 and 10 percent very conservative.

Senator Percy. Now, finally, getting into some of the implications on how we make payments it seems to me that percentage arrangements are just that. I am always suspicious of percentage arrangements, I would rather have a flat fee. I don't want them to have an incentive to find ways to spend money. Now don't you think these percentage arrangements ought to be illegal and no reimbursement paid to contractors, employees or related organizations and not have them recognized if there is a percentage arrangement involved?

Mr. Halamandaris. Yes, sir.

Senator PERCY. I think that, alone, would remove one of the administrative problems that we have and that the Secretary's determination of the reasonableness of cost or charges would include consideration of the relationship between the direct and indirect overhead costs or charges in the direct cost of the provision of service. In other words, they would have to see what this superstructure is that has been established so that they would have to find some way to get behind it.

Now don't you think it would be desirable for a provider or an agent, when requested by the Secretary or the Comptroller General of the United States, to provide a full financial disclosure as to the arrangements? Who owns them? How much they are getting in rent? Who is skimming off the cream on the top? Who is making the money on this operation? There is no reason, as long as it is public money, why that should not be provided as information basic to the establishment of the treatment.

Mr. HALAMANDARIES. I could not agree more.

Senator PERCY. Then, finally, the closing of loopholes in the law. We have found some loopholes particularly in the payment of medicare and medicaid reimbursement to anyone other than the billing physician or hospital.

Lastly, I am really shocked to find that fraud under medicaid and medicare is now statutorily a misdemeanor. This bill would change it. The fraud will be punishable as a felony with penalties up to 2 years imprisonment and a $10,000 fine.

Now that is the exact same mechanism we used last year in a bill we unanimously adopted to really try to stamp out fraud in these student loan programs. I think these people realize they are going to go to jail and they are going to pay heavily and it is a crime, it is a felony, and not just a misdemeanor, for them to be robbing, stealing the public blind and taking advantage of the kind of people that all of us represent.

PEOPLE BARTERED LIKE PROPERTY

You can imagine the attitude of people when they sit and listen to them being bartered like a piece of property as to how doctors can actually make money, and what attitude do they have toward society and their Government when you see it going on right under their own noses? The experience that you have had, I am sure, is hardened. Maybe there is cause for a lot of crime in the ghetto level where people figure there is just no way to beat the system—the system is set up for those who are benefiting from it, not us, we are just being taken advantage of. I think you performed a truly remarkable service.

Senator, I just want to say once again to you, to be able to take your shirt off and get in there and put those coveralls on—you are going to have religion like no one has had it—no one is going to be able to stand up to you on the floor and say this bill is not really necessary.

Senator Moss. Thank you.

Senator Beall.

Senator BEALL. I agree with Senator Percy's analysis of this legislation and the need for an inspector general certainly.

I ought to point out that about a year or two ago, Secretary Weinberger included the request for a team of fraud investigators in the HEW budget request and the Senate Appropriations Committee cut that request out of the budget. As a matter of fact, it subjected the

Secretary to a great deal of abuse during the hearing process, accusing him of trying to set up a "plumber" type operation. I think some previous Secretaries have also raised the need to establish a fraud investigation unit of some type.

Mr. Halamandaris, do you associate the difficulties in controlling medicaid with the fact there is joint control between the Federal Government and the State?

Mr. Halamandaris. I do, sir, definitely, jurisdiction is split between the Federal Government and State government and in some cases with local jurisdictions as well. It's like Abbot and Costello playing baseball—I have got it, you take it. The responsibility seems to fall between the cracks.

Senator Beall. Some States are doing a good job and some States aren't.

Mr. Halamandaris. Correct, sir, the better States include California, Michigan, and New Jersey.

Senator Beall. What about Maryland?

Mr. Halamandaris. Maryland is one of the better States.

Senator Beall. Second, would the illustration you point to come from large urban areas?

Mr. Halamandaris. That is right.

Senator Beall. We have just passed health manpower legislation through the Senate as you know. Is it true that most of these situations occur in areas where there is not an adequate supply of primary care physicians and probably results from the maldistribution of health personnel across the country?

Mr. Halamandaris. I believe that is a fact, yes, sir.

Senator Beall. Do you find these abuses in rural areas, too?

Abuses Found in High Density Areas

Mr. Halamandaris. We have not found abuses in the rural areas. The mills exist in high density urban areas. If you travel to Chicago or to Los Angeles, you'll see them dotting the landscape almost like the pornographic book stores.

Senator Beall. There is no available alternative for people who are sick? There is no other facility to be used other than this store front operation?

Mr. Halamandaris. That is the best thing that can be said about medicaid mills, they are located in the ghetto. But so many people told us: "We don't go there if we're really sick. If we're really sick, we go to the hospital emergency room."

Senator Beall. Thank you.

Senator Moss. Thank you very much.

In New York the responsibility financially is 50 percent Federal, 25 percent State and 25 percent in the city, is that right?

Mr. Halamandaris. That is right, sir.

Senator Moss. So that is a three tiered financial responsibility which leads, as you say, to the scrambled lines and the failure to take full responsibility for audit and inspection and policing and so on.

Well, I want to say again how much I appreciate the work done by this staff. It must be realized that we are simply a subcommittee of the special committee and we don't have a lot of manpower or a lot of facilities to carry on this kind of investigation and it was because of

the pressing needs of this that the staff has devoted itself so wholeheartedly to this matter.

While I am speaking about that, calling on the Capitol Police force to suppy some manpower and some assistance to us was an innovative thing to do and certainly the two men who were assigned did an exceptionally fine job. I have here this morning a letter that Senator Church who is chairman of the full committee executed and I want to give this to each of those men for the outstanding work that they did. Their devotion was great indeed as it was for the entire staff in this matter.

The report that has been prepared is an excellent one. It covers an area of great importance to us.

I think we are going to have to involve other committees of the Congress as we are doing now with the Finance Committee and others to supply the added manpower we need to make sure we have got this thing in hand.

Is there anything further to be offered?

Mr. HALAMANDARIS. No, sir.

Senator MOSS. Let me thank you all very much.

Let me ask Private McDew and Private Roberts if they would come up here and let me give them each a letter.

[Letters presented to Private McDew and Private Roberts.]

Senator MOSS. We will now hear from Dr. Bruce P. Reiter from the city of New York.

Dr. Reiter, will you come forward, please.

We welcome you before this committee. We appreciate your cooperation and your willingness to come and we would be glad to receive your testimony at this point.

STATEMENT OF BRUCE P. REITER, M.D., NEW YORK CITY

Dr. REITER. Good morning, Mr. Chairman and Members of the Senate.

My name is B. P. Reiter, and I am a physician. I am a graduate of the Albert Einstein College of Medicine in New York City. I trained at Metropolitan Hospital, the Kingsbridge VA Hospital, and at Bellevue. In 1975 I was certified by the American Board of Radiology as a specialist in radiology.

I am a physician, and I also do a bit of writing. If you will indulge me, I will read a few things that I wrote in New York Magazine some while ago.

Once I finished medical school, I figured I would go out and get rich. Not superrich, but rich enough to move out of my one-room apartment. I also wanted to buy a new motorcycle, and perhaps pay off a few of the constellation of loans I had collected in medical school.

I could do none of these things. It turned out I had an M.D., but I had no license. You need at least a year of internship in order to get a license to practice medicine. I went and did an internship. A lot of interesting things happened; but I survived. And I got my license.

Well, I thought, now I'm going to go out and get rich.

"What are you talking about?" my friends said. "You have to specialize."

"I do not want to specialize," I said, "I want to get a job."

"You can't get a good job unless you specialize in something."

I specialized in something. Three years later I had my M.D., my license, and my specialty. I'm not going to talk to anybody this time, I thought. I'm just going to go out and get rich. I planned to open an X-ray office.

I called the X-ray equipment company and said, "hello; I'm a young radiologist and I'd like to open an office." The X-ray equipment company said no problem, they could set me up, on a modest scale of course, for about $220,000. "Oh," I said.

I didn't have $220,000. If I'd had $220,000, I wouldn't have opened an office. I would have closed the office and gone to Jamaica fishing.

Well, I figured, maybe I can find a job in the New York Times. What with the doctor shortage and everything, there ought to be a job some place for a radiologist.

Indeed, there was a whole string of ads in the Sunday Times. "Medicaid Clinics! Serve the community! No overhead, no investment, high volume. All types of doctors needed. Should speak a little English."

I speak a little English, I said to myself. I called up one of the clinics.

"I'm a radiologist," I said, "and I was wondering . . ."

Medicaid Mills Hard to Miss

"Come in," they said. "Come in and see us!" I drove to Brooklyn the next day and found the place. It was hard to miss—there was a gigantic, multilingual sign out front advertising medical care, dental care, chiropractic care, any kind of care you wanted. Everything but topless waitresses. Right next door, a similar, slightly smaller sign identified a conveniently located pharmacy. Also gladly accepting medicaid.

I went inside. There was a small waiting room, with a very big guard standing in the corner. I walked up to the little glass window.

"Hello," I said, "I have an appointment here."

"What?" the woman on the other side said through an intercom thing.

"I have an appointment. I am a doctor."

The piece of plate glass between us was about 3 inches thick, and she couldn't hear anything. It was like a checkcashing place on the Bowery. "What?" she said again.

"I said I'm a doctor," I yelled. "I've got an appointment!"

The guard came over and shook his stick at me. "Sit down and be quiet," he said to me, "or you won't get your methadone."

"I don't want any methadone," I said. "I'm a doctor and I have an appointment about a job here."

"Sit down and be quiet," the guard said, looking nasty. He was twice as big as I was and I sat down.

I looked around the little waiting room. This was a high volume operation all right, no question. I had to take a seat way in the back, but there was another great big sign up front with an illuminated, moving message. It was certainly big enough and bright enough not to be missed, even from the cheap seats.

"V.D. Tests," it announced in several languages. "Pregnancy Tests, Pap Tests, Road Test, Learners Permits, Auto Insurance, Life Insurance, Personal Loans—Low Rates."

"What am I doing in this place?" I said to myself. Two gentlemen dressed up in long white coats appeared from behind the armored window and came hurrying over to me.

"Are you the doctor who called up yesterday?" the smaller one said. "The radiologist?"

I admitted I was the radiologist.

"Wonderful, wonderful," he said. "This is my partner. Come with us, doctor."

We went inside. The guard did not frisk me but he looked like he wanted to.

The three of us sat down in a plasterboard office that had padlocks on everything.

"Would you like a cigar, doctor?" the little one said.

"No, thank you," I said. "I'd like a job. I finished my residency last June and I'm pretty well trained in general radiology, isotopes and angiography."

Furnish Everything for 70 Percent

"That's very nice," he said. "We take 70 percent."

"Pardon me?"

"You give us 70 percent of your billing."

"I don't understand," I said.

"Let's say you become our radiologist," the little one said with a kindly look on his face. "We handle everything for you. We take care of all the equipment, we buy the film, we pay the technician. All you have to do is read the films."

"I see. Well, who supervises the technician's work?"

"Oh, we do," the big one said. "We watch him very closely."

"Yes," the little one said, "you don't have to worry about anything. All you have to do is read the films and give us 70 percent of your billing."

"Seventy percent? You're kidding."

"This is a wonderful opportunity for a young doctor like you," the little one said enthusiastically. "Do you know how much that equipment costs?"

I knew. "Well, I'm not sure," I said. "I mean, that doesn't leave very much for me."

"Look at it this way. This is a very high volume clinic. Let's say you have $1,000 worth of billing. That's $300 a week for you right there. By the way, have you ever done any medicaid work before?"

"No. This is my first job."

"Well, there's one more thing," the big one interjected. "We like to get paid right away."

"Yes," the little one said, "that's true. We have a lot of overhead."

"What do you mean?" I asked innocently.

"It works like this. Let's say there's $1,000 worth of billing for 1 week. You come in and read the films, you pick up the invoices, and you give us a check for $700. For our overhead."

"You mean I have to pay you to work here?"

They both chuckled. "No, no, doctor," the big one said. "You're looking at it the wrong way. You send the invoices to medicaid and they pay you the $1,000. And you've got $300 free and clear."

"How long does that take?"

"Oh," the little one said casually, "not more than 4 months."

"Wow," I said "You mean every week I give you $700 and 4 months later I get it back from medicaid?"

"Well, more or less. You know, we have to meet our overhead here."

"I'm sorry," I said, getting up. "I don't have any money. That's why I was looking for a job."

"Sit down, sit down," they both said, still extremely genial. "No problem, doctor. We'll take care of everything, don't worry. We factor."

"Oh," I said. "What's that?"

Factoring Covers 4 Months Wait

"We'll help you out. We have a company that loans money to young doctors. You know, just until the bureaucrats at medicaid get around to sending out your checks. That 4 months can be a long time."

I was learning. "How much?" I said.

"Just 10 percent. We try to help our doctors along."

"You're joking," I said "That's 30 percent a year. How much do I keep? Eleven dollars?"

The two of them chuckled again. "You'll do very well," the big one said, "don't worry. It just takes a while for a young fellow like you to get started."

"You mean," I summed up, "you loan me money at 30 percent a year, and I lend the same money back to you for nothing? That's crazy."

"You're looking at it the wrong way, doctor," the little one said.

"I don't think I can afford to work here," I said.

They changed the subject. "Say, would you mind looking at a case for us? Our last radiologist got discouraged and left. This patient's been waiting weeks for his results."

I love to look at films. I examined their case for them, holding the films up to the window and squinting at them. It was an oral cholecystogram.

"Where are the rest of the films?" I asked. "This is a very incomplete study."

"Well," the little one said, "things have been kind of slow. The technician tries to save us a little money sometimes—the film is expensive. We've got a lot of overhead, you know."

"Yeah," I said, "you must have some electric bill for all those signs out there."

I inspected the films again and made a learned discussion about adenomyomatosis and cholesterolosis. The little one looked at me absoluately blankly.

"What?" he said.

I figured maybe he was a psychiatrist or something and he had been away from clinical medicine for a while. "What's your specialty, doctor?" I asked politely.

He thrust his hands into the pockets of his white coat and leaned back in his swivel chair."Oh, I'm not a doctor," he said.

"Well, who are you?" I asked.

"I'm the executive administrator," he said. "My partner is the doctor."

I turned to the bigger one. "What was your feeling about this case?" I inquired.

"Me?" he said. I'm a chiropractor. We have a different concept of disease, you know."

"Oh boy," I said.

A family with a large number of children wandered into the office. "Excuse me," the mother said, "is this where we find out about the apartment that's for rent?"

"No, no," the chiropractor said, hustling them out, "that's down in the basement. Go back downstairs."

He came back in looking annoyed. "I don't know how they got past the guard," he muttered.

"Oh yes, there's one more thing, doctor," the chiropractor said. "Some of the patients don't have medicaid or medicare, so you read those films for free."

"You mean like for indigent patients?" I said. "Sure, that's okay."

The chiropractor looked at me oddly. "We have no indigent patients," he said. "I mean for private patients."

"I don't understand. Why don't you bill the private patients?"

"Oh, we bill the private patients," the chiropractor said. "You don't bill them.It's sort of a service you provide for us."

"I still don't understand," I said. "Why do you get paid if I read the films?"

"Well," the chiropractor said, "with cash changing hands and everything, it's just easier. Ask around, all the medicaid clinics work that way."

"Yeah," I said, "I bet they do."

Diagnosis Never Normal

It was the executive administrator's turn. "There's just one more thing," he said, holding up an invoice. "See where it says 'diagnosis'? Never put down 'normal,' no matter what."

"But suppose that the films are normal?" I said. "Don't you ever ever get any normals?"

"Oh, yeah," he said, "all of them are normal, just about."

"Well, what am I supposed to put down?" I asked.

"It doesn't matter what you put down," he said, "as long as you don't put down 'normal.' "

"You mean you want me to make things up? I can't do that."

"No, no, of course not," the executive administrator said, beginning to look impatient. "Just use the referring doctor's diagnosis."

"This is getting kind of tricky," I said. "Is this legal?"

"Would we break the law?" the executive administrator said. "Let's go downstairs, and we'll show you."

We all went back downstairs. The chiropractor had to go and reprimand a patient who was kicking the soda machine. The executive administrator led me to a tiny examining cubicle with "Dr. So-and-so, Doctor of Chiropractic" on the door.

"This is Dr. So-and-so," he said. "Dr. So-and-so, this is the new radiologist. He needs some help in learning how to fill out the invoices."

The chiropractor was crowded into the little room with a young, hulking, very healthy-looking patient. There were a couple of view-boxes on the wall and this chiropractor was looking at some curvical spine films. Parenthetically, upside down. He stood up.

"Glad to meet you," he said. "The invoices are a snap to fill out." He gestured at the X-rays. "This young man, for instance, is suffering from a cervical radiculopathy."

"A what?" I said.

"A cervical radiculopathy. Look at the films."

I went over and, as casually as I could, turned the films right side up. "Where?" I said. "I don't see anything."

"Right there," the chiropractor said, pointing. "Look at those spurs."

"Those little osteophytes? Everybody has them. That's practically normal."

The chiropractor gave me a very hostile look and motioned me out into the corridor. He closed the door on the patient.

"What's the matter with you?" he said. "Do you want the patient to hear you?"

Film Shots Held to Minimum

"But there's nothing wrong with him on those films," I said. "Besides, if he's got neurological symptoms you've got to look at the neural foramina. You can't even see those on the lateral films. Where are the oblique films?"

"All you M.D.'s think you're so smart," the chiropractor said, retreating back into the examining cubicle. "You guys give me a pain in the ass." He slammed the door.

The executive administrator took me by the arm. "We don't take that many obliques here," he said. "We find we don't really need them. Don't worry, you'll catch on. Where are you parked?"

"Right out front."

"Come on, I'll walk you out to your car," he said expansively.

"Is the interview over?"

"Sure, sure," he said, lighting up a large cigar. "All these details are simple. Don't worry about them. You know, we're opening a new place in Queens next month. You might be interested in doing some work for us out there, too. We're going to have a real empire. You're pretty lucky—you can get in on the ground floor."

We walked out into the street. "Oh, that's too bad," he said, looking at my ancient Volkswagen—about 10 or 15 years old. "You've got M.D. plates on your car."

"What's wrong with that?" I said.

"Well, nothing. Just keep changing your schedule. You know, don't show up at the same time every day. Otherwise you might get jumped."

"Me?" I said. "Why would anybody want to take me off? I don't have any money."

The executive administrator looked tolerant and amused. "The methadone. They'll think you've got the methadone. See you Monday."

This is not fiction, as I am sure you are aware by now; this is just the beginning, as a matter of fact. What makes a medicaid mill like this, a reprehensible place like this, possible? Why do they spring up? Legislation was passed that provided money to help take care of older people, of poor people. What happened?

This is an opinion, on my part. I think a couple of things happened. First of all, an enormous amount of regulations, guidelines, and rules spewed forth, from a number of different agencies. I don't own a medicaid center, I am just on the list of what they called "vendors." This is some of the stuff that I got, telling me what to do, when to do it, when not to do it. [Holds up large pile of forms.]

These two sheets, with single-spaced typing on both sides, with some pictures, two of these sheets deal exclusively with the medicaid ID card. When you can't treat patients or when you can treat them. The rules and the guidelines and the regulations and the forms all keep changing, keep altering, and when you comply with them, they are followed by silence. When you treat a patient and you then want to get paid for it, it takes 3 months, 4 months, 6 months, 8 months to get paid. When you get paid, if you do, you get paid almost at random, it seems to me. You get "reduced," which means patients' names come back with code numbers on them. You call medicaid, and they hang up on you. You call again, and they hang up. You call the third time and you say, "Don't hang up, don't hang up, I just want to get the forms to get paid."

"Oh, sure, we will send them right out." They never do.

Structure Promotes Abuses

Then, when you do get paid by medicaid you really don't get paid particularly much. There is a bad effect from these things. What happens, I think, is that this structure—of papers, of forms, of changing rules—tends to disgust those people who are there to deliver health care, those people who are there to take care of sick people. It selects out against those doctors who simply want to take care of sick people, and selects into the process those people who are willing to sit down with their lawyer, and their accountant, and figure out just what the latest medicaid form says and what it does not say, and, more to the point, figure out how to outwit the very regulations that are supposed to contain the kinds of abuses they commit.

One of the reasons for this happening is that, to sit down and open a medicaid mill, you don't have to be a physician, or dentist, or podiatrist, or even a chiropractor. All you have to do is get a big sign that says "medicaid clinic," and you are in business. For the people who own medicaid mills, taking care of sick patients is something that they have to live with, just like income tax or overhead. It is something for them to do as cheaply and as efficiently and as quickly as possible. To be gotten out of the way, so they can attend to the business that they are there for—which is to make money and generate profits.

Now, I am not against profits. I would very much like to make some profit myself—to get a haircut, maybe get a new motorcycle.

But my concept of medicine is a doctor, in an office, with a patient, and my concept of medicine is not some guy who has never even considered what it means to be sick, or frightened of dying, or getting old. I think it is disgusting that a businessman, an individual who is just a young hustler, a guy that is younger than me, can sit there with his lawyer and accountant and figure out how to generate money out of people's illnesses.

Thank you.

Senator Moss. Thank you, Dr. Reiter. Your rather humorous recitation carries through the bitter disillusionment that came to you and reflects to us. To have you come back and explain, perhaps trying to be sure that the proper steps were taken and real attention given to the whole thing which is bogged down with a long list of forms and outline and a lot of material impedes rather than enhances the delivery of the medical care that people need.

Like you, I am frustrated in knowing how we get between these two. How do we get people who are trained as doctors in various specialties to care for their patients and to appropriately reward them for those services and not fall off on either side?

We constantly feel the necessity of pointing out that we still have great faith in the medical profession and most of them, the vast majority of them, want to serve. That is the reason they took all that training and went into that field. Others have been able to abuse the system and we need some way to try to single them out.

Care for Poor and Old As Real Purpose

Your experience is—unfortunately I guess it occurs to others who find themselves one way or another introduced into this system. Hopefully we will find a way because we are anxious to see that care is given to the poor and the old and those who are unable to go in the regular channels that most of us can go when we need medical care. That is the purpose of this whole hearing.

I cannot tell you how grateful we are to have you come and put this thing down clearly on a personal basis before us so that we can look at it and see if we know the way, and maybe we don't, but we have to try and struggle to try to find a way to make the system work out and enable people to get the medical care that they need and to which they are entitled. So I want to thank you.

Are you practicing alone, Doctor, or what kind of practice do you carry on?

Dr. Reiter. I am a writer. I have just finished a novel, "The Saturday Night Knife and Gun Club."

Senator Moss. You just write now, you are not actually practicing?

Dr. Reiter. I still don't have $220,000 to open an X-ray office.

Senator Moss. I can understand.

Dr. Reiter. If I could add another parenthetical remark about that. To open a private X-ray office, one does need a quarter of a million dollars. The one medicaid clinic, for example—although this is quite common—that I spoke of here, which collected 70 percent of the fees from the radiologist's work—supposedly for the service of providing this very expensive X-ray and the X-ray technician—outfitted their X-ray facilities for $8,000. Secondhand equipment, that cost them $8,000.

Senator Moss. Cost $8,000.

Dr. Reiter. Now, keeping in mind that about a quarter of a million dollars worth of stuff is needed to set up an adequate and competent office, which has the equipment to do the proper kinds of examinations and procedures, and only $8,000 these fellows shell out, you can imagine what kind of stuff they are working with there. That is routine, too.

Senator Moss. Yes. As you may have heard some of the other shoppers report being given X-rays, sometimes not even plates and sometimes the dental X-ray equipment to take X-rays of feet and things of that sort indicating the absolute ludicrous lack of equipment that is used simply again to generate dollars.

Dr. Reiter. If I could indulge in one tiny bit of propaganda. The question was posed before about organized medicine. What, if anything, have the medical societies done? I belong to the State medical society and in fairness to them, there is a little note which I have got here that points out that last spring the New York State Medical Society sent a delegation to Albany to specifically request that the percentage leasing arrangement—which seems to be one of the linchpins of these medicaid mills—be made against the law or against the regulations or against something. The board of regents, which I think received that request by the State Medical Society in New York, has recently declared that such an arrangement is "unprofessional conduct"—which means that one's license can be taken away upon conviction for that charge. This may have some effect on the leased-space facilities where the rent is calculated on a percentage basis and the practitioner frequently receives only a small part of the fee paid. I think some credit should perhaps be given to the medical society there. They did move.

Help Furnished by Medical Society

Senator Moss. I am glad to have you point that out. I think there is some movement and I expect more yet will be done by the medical society. Perhaps it is slow to move but I think they will move now in a lot of this area.

The Senator from Illinois.

Senator Percy. Doctor, how many were in your graduating class? Where did you graduate for medical school?

Dr. Reiter. I went to the Albert Einstein Medical College in the Bronx, New York.

Senator Percy. How many were in your class?

Dr. Reiter. We graduated something over 100. This is a guess. Between 105 and 110.

Senator Percy. Did they all go on to specialize?

Dr. Reiter. Heavily, yes. I would say that, yes.

Senator Percy. In your own specialty, how many were in that class when you got your degree?

Dr. Reiter. Well, at the stage we graduated we had not yet specialized. We all took a year of general internship, or did at that time, and then subsequently went on to specialty training. This is off the top of my head, but I estimate 8 percent, 9 percent, something in that range, of my class entered radiology.

In terms of how many of our people went into, let's say, internal medicine, family practice, pediatrics and gynecology, which is more or less the group of primary physicians that patients first come to see, I am really guessing now—58 percent in 1974.

Senator Percy. Do you know any members of your graduating class that have actually gone to work in a medicaid mill or have they all gone into hospitals, private practice, perfectly legitimate pursuits of their vocation?

Dr. Reiter. To my knowledge I am the only individual from my class who had the distinction of working with the medicaid mills. Generally speaking, these kinds of operations don't attract American graduates of American schools. As was pointed out previously, they kind of tend to prey on the doctors, as well as on the patients, and they single out a lot of doctors from other countries who don't have that good a grasp of the language to begin with, who are overwhelmed by the idea of setting up a practice, and attracting patients and all the associated complexities. That is an intimidating situation to be in, and can be taken advantage of.

Senator Percy. From the very fact that in the ad you commented, some knowledge of English was necessary, wouldn't the assumption be that essentially they are trying to attract the foreign born and trained doctors who for one reason or another possibly can't get a license to practice in this country and therefore would be eligible to work in a medicaid mill but not other places? Is that generally the kind of person that ends up there? How would you describe the kind of people that you have met who end up in the medicaid mills?

Foreign-Trained Physicians In Mills

Dr. Reiter. Well, as I understand it, one has to have a license to be reimbursed by medicaid—I am not 100 percent sure of this, but I am fairly certain. If that is the case, then obviously they are licensed. But again, there are all kinds of licenses. Someone who is a perfectly competent physician in his own language, may have adequate credentials elsewhere, and have gotten an equivalency license in this country, and still be overwhelmed by the unfamiliar situation of a new culture. I would agree with you, and with the speakers who were here today, that the medicaid mill physicians seem to be foreign-trained.

Senator Percy. You said that you started out with the intention, honestly stated, of making some money and getting rich. Now when an opportunity was offered to you to make some money, and possibly get rich, why did you turn it down?

Dr. Reiter. I didn't go to medical school for that.

Senator Percy. You didn't what?

Dr. Reiter. I didn't go to medical school for that. I went to medical school to be a doctor. Even though there is a problem with bad apples, I think there is still quite a selection process that goes on, starting at the point when you apply to medical school in this country. I would like to think that the bulk of our people come out of medical school with pretty much the same ideals that they took with them when they went in. I think to a large degree that is true. I hope it is true.

Senator Percy. By your testimony you said, once you finished school you figured you would go out and get rich, not super rich but rich enough to move out of your one room apartment and buy a motorcycle.

Dr. Reiter. Yes.

Senator Percy. In other words, the association here simply was not the kind that you were willing to connect yourself to though it did involve making money?

Dr. REITER. I want to practice medicine; I am a physician. These medicaid mills people are not doctors. The people who run these places are not there to provide medical care. This is not like going to a bunch of doctors and saying, "What can you give to your community" and joining their group and seeing patients. This is just a scheme for grabbing a lot of Government dollars; it has nothing to do with practicing medicine.

Senator PERCY. How did you come to the attention of our subcommittee staff?

Dr. REITER. Mr. Bill Halamandaris called me. Apparently he looked at the article I had published, which I quoted to you, in New York magazine last summer. He asked me to come down.

Senator PERCY. You were aware of the work of this subcommittee and the interest that we had in this field?

Dr. REITER. Not in detail, but yes.

Senator PERCY. Thank you very much.

Dr. REITER. My pleasure.

Senator MOSS. Thank you very much, Dr. Reiter. We surely appreciate your coming and adding to our hearing record.

We have now Joseph Rodriguez who is chairman of the New Jersey Commission of Investigation. He will be accompanied by Anthony Dickson who is counsel to the commission.

We made some reference to New Jersey earlier and what they have done so we are very pleased to have Mr. Rodriguez here. He also has a report that I understand he will present and if he does that, we will make that report part of our record.

STATEMENT OF JOSEPH H. RODRIGUEZ, CHAIRMAN, NEW JERSEY COMMISSION OF INVESTIGATION, ACCOMPANIED BY ANTHONY G. DICKSON, COUNSEL

Mr. RODRIGUEZ. Thank you.

Mr. Chairman and distinguished members of the committee, on behalf of the New Jersey State Commission of Investigation, known as the SCI in New Jersey, I would like to thank you for this opportunity to appear before you and testify about the commission's investigation of the practices and procedures of practitioner groups receiving State and Federal moneys under the medicaid program. I understand that this committee is currently considering regulatory and statutory reforms on the Federal level to correct certain harmful abuses in, and exploitation of, the practitioner component of this well-intentioned program. By a report first made public here today and by our testimony we are prepared to share with you our insights concerning the operation of the medicaid program and our suggestions concerning its reform and improvement.

By way of background, let me briefly tell you something about the New Jersey SCI and the manner in which this particular investigation of practitioner groups receiving medicaid funds and the report [1] which we release here today were developed. At the outset I wish to make it clear to you that the New Jersey State Commission of Investigation has no role in the administration of the medicaid program. Our

[1] See appendix, p. 599.

investigative staff of less than 25 is charged with the responsibility of advising the State legislature and the public of problems of organized crime, official corruption and any other matter affecting the public trust. We have no prosecutorial powers but like the Ervin Committee we do have the obligation to fully investigate particular problem areas, report our findings to the public and recommend a course of curative action to the legislature.

Early in 1975 the commission began an evaluation probe of the entire medicaid program in New Jersey at the request of our Governor, Brendan T. Byrne. The SCI proceeded to set up three investigative teams to look into three principal medicaid cost areas—nursing homes, hospitals, and other purveyors of services, including independent clinical laboratories, professional practitioner groups and pharmacies. The commission has held public hearings and issued reports in many of these areas and more are shortly forthcoming. We have testified before several congressional bodies—including this distinguished committee—concerning the results and recommendations which stemmed from our investigation. Our probe into medicaid ripoffs by independent clinical laboratories was the subject of a national television network's documentary aired in April of this year.

In this investigation the commission centered scrutiny upon the practices and procedures on a sample of relatively large dental and physician groups, their relationships with other providers of medical care and services—especially pharmacies—and the adequacy of existing regulations and integrity monitoring methods utilized by the State body administering the medicaid program, the Division of Medical Assistance and Health Services.

Investigation Focused on "Professional Centers"

The commission focused upon practitioners associated together in professional groups, "professional centers" housing various unassociated tenant practitioners and offices of single practitioners in which other physicians would regularly share space in either an employee or independent contractor capacity. More than 12 facilities located in welfare project highrise buildings, converted stores, warehouses and tenements in impacted areas across the State—each having at least a 75-percent volume of welfare patients and bringing in substantial medicaid moneys yearly—were examined.

The commission received valuable and full cooperation from the Division of Medical Assistance in this investigation and established a working relationship with Val Halamandaris and other staff members of this committee. Books and records were subpoenaed and reviewed, facilities were visited by investigators of the SCI and the Select Senate Committee on Aging who posed as patients, and sworn testimony was taken from practitioners, facility employees, medicaid recipients and State program administrators.

The facilities which we examined typically were divided into a reception area for patients equipped with rows of theater-type seats and several smaller compartments used for patient examination, X-ray services and laboratory services. Several locations also contained in-house pharmacies. Each facility had an owner or equivalent of a business manager to supervise the day-to-day running of the operation, take on and terminate medical, nursing, and clerical staff, and

arrange liaison with out-of-house specialists and suppliers of goods and services. In many cases, the owner or business manager was a layman.

Through examination of books and records and sworn witness testimony, the commission was able to discern the financial arrangements between the staff or tenants of the facilities and their owner/operators. In early years of the medicaid program many facilities paid associated physicians a salary, which in some cases amounted only to $15 per hour. The facilities received all fee for service medicaid moneys accruing because of these practitioners and, in many instances, the amount could be hundreds of dollars per hour. We strongly doubt that the drafters of the medicaid program or professional groups which loaned their support to it envisioned such practices.

Nor do we believe legislative draftsmen on the Federal and State level foresaw the rise of percentage arrangements between professional practitioners and facility owner/operators whereby the practitioner would keep from as little as 30 percent to as much as 70 percent less $100 monthly of the fees for service paid by medicaid. The Commission identified several such relationships and on the average practitioners were required to turn over 50 percent of the taxpayers' money they received to facility operators or landlords. For their 50 percent operators and landlords provide space, telephone, nursing and clerical service. This latter "service" usually consisted of the presence of the operator's secretary to keep accurate tabs for the owner/operator of amounts billed by the practitioner.

Percentage Arrangement Unrealistic

The Commission recognizes that certain expenses are indeed borne by the facility but suggests that economies of scale accruing to large facilities should lessen the necessity of high percentage arrangements. We believe that these percentage arrangements should be outlawed. As our report indicates, they are incompatible with the goal of providing necessary quality care to recipients at reasonable cost to taxpayers. Such arrangements foster overutilization. It is unrealistic to expect program providers to practice fiscal restraint when the amount they earn at a facility directly depends upon the amount billed.

Percentage arrangements also incite "ping-ponging" which was defined here today, and our report also defines what we found in New Jersey as "family ganging"—a practice which we define as requiring a patient to return without medical justification to the facility for billable visits. They receive one medicaid patient and then require that the entire family go in for medical care. They call that family ganging.

The Commission received sworn testimony from physicians and facility staff indicating that owner/operators—very often lay owner/operators—would leave instructions for patients to be referred amongst the various in-house specialists and pressured physicians to follow instructions. Your own investigators can tell you how they were scheduled by clerical personnel to return to facilities for visits to dermatologists, radiologists, podiatrists and other specialists prior to being examined or even seen by a physician. They also can tell you of the brief amounts of time spent upon them by examining physicians

and you can review for yourselves the office visit charges in excess of $30 for the visit.

You can compare the statements of your own investigators with bills which your investigators were required to sign in blank and which were submitted by New Jersey physicians and find requests for payment for blood which was not drawn, injections which were not given and urinalysis and tine tests which were not performed, and even drugs billed for patients who had been dead for weeks. We know of cases where lay owner/operators have themselves steered patients into the house pharmacy or contacted the associated drugstore by direct phone link to have prescriptions filled and even a case where a lay facility administrator examined and prescribed medication for a female recipient. Our report also outlines the X-ray abuse for charging each time when the eye focuses rather than when the shutter snaps.

Dangerous Corner Cutting

We also found that facility owner/operators try to decrease their own expenses wherever possible. Your own investigators who visited several facilities in New Jersey with our staff will tell you of the filthy premises they often encountered. Our investigative record, which we leave here with you today, will demonstrate instances of potentially dangerous corner cutting through the use of untrained clerical personnel to administer injections and physical therapy treatments which were billed as if physicians actually performed the service.

Medicaid moneys were received unjustly by practitioners who billed the program for office visits when recipients telephoned for prescription renewals. Testimony indicates the decision to renew particular medication was often made by clerical personnel. Practitioners also billed medicaid and insurance companies for services rendered to recipients involved in accidents. In these instances the public paid twice—first in higher insurance premiums and second with tax dollars assigned to medicaid.

One facility and pharmacy in New Jersey which is contained in our report were involved with others in an ingenious scheme designed to maximize personal property. A lay entrepreneur who owned property banded together with a relatively small group of physicians, pharmacists and clinical laboratory operators to form a company which would arrange for laboratory tests to be performed, and repackaged and resold relatively inexpensively generic drugs under its own name. Stockholders included the physicians who would write prescriptions for their corporation's products and lay medical facility owners. For these prescription sales, stockholder equity in the corporation increased. Questions of product quality aside, such a situation raises grave questions of conflict of interest and temptation to overutilize scant medicaid program funds.

One product so administered to that corporation was a tonic which one doctor described as having as much alcohol as Old Grand Dad. Certainly this practice represents a blatant conflict of interest and should be prohibited.

We have also brought along with us a modest example of the prescriptions which were prescribed for your so-called healthy investiga-

tors who visited the State of New Jersey. We brought a modest sampling with us, yet they were billed for many and the prescriptions were never filled.

We have purposefully covered the names of the pharmacies that are involved because we intend to submit our report to the law enforcement agencies of the State of New Jersey for possible criminal prosecution and we thought for the purposes of this hearing we would have the pharmacies' names blanked out. This is a modest example of so-called healthy people being prescribed for medication.

We wish to point out that many of the abuses outlined here today—extensive use of paramedical and even lay personnel for duties which are reimbursable only to physicians, double billing, ping-ponging and family ganging—can be and are being detected by the State Division of Medical Assistance and Health Services through the use of sophisticated computer screens and the time studies. We commend the Division and specifically the Bureau of Medical Care Surveillance for the effectiveness of current methodology. Existing computer program comparison procedures, however, do not uncover abusive practices in each and every case but only when certain factors are present.

Undercover Agents Effective

To further protect the integrity of the program, we recommend that New Jersey and all other States obtain and regularly employ the services of undercover agents who would pose as recipients seeking medical care. The Commission found that the use of such agents provided a quick, reliable, and efficient method of uncovering practices inconsistent with the aims of the medicaid program. Evidence gathered by such investigators could and should be aggressively used in suspension hearings or passed along for the review of appropriate law enforcement agencies.

At this point I would like to personally thank the members of the Capitol Police and investigators from this committee who assisted our investigators in obtaining some of this information. I would, if I may, take the personal privilege of pointing out that we affectionately call the following—runny nosed Oriol, earache McDew, sneezy Roberts and a-choo Hawes—and thank them for their heroic services in obtaining this medical care when it was not needed and incurring the risk many times of potential overradiation when X-rays were required in a haphazard manner.

We additionally recommend that facilities performing substantial amounts of medicaid work be annually inspected and registered. As a part of the registration procedure, facilities should disclose to administering agencies the names and positions of employees. This information which, of course, should be updated periodically, will prove helpful in detecting use of paraprofessionals in place of physicians. We would also suggest that the administering agencies consider legitimatizing the use of qualified medical paraprofessionals in certain instances. Services rendered by such individuals, however, should be paid at a rate lower than that now designated for physicians.

We also recommend that administering agencies consider the possibility of contracting with an insurance clearing house. Our own experience indicates this to be an effective step in obtaining reliable in-

formation on the presence of sources of medical payments other than the medicaid program.

Lastly, we urge that steps be taken to insure that recipients be made aware of services billed to medicaid on their behalf and be given an opportunity to challenge the accuracy of physician requests for reimbursement. At the very least, a procedure should be instituted and strictly followed requiring recipients to sign only completed, itemized claim forms. We further recommend that recipients be advised of services billed on their behalf, either by a State compiled listing of billings periodically through the year or simply by adding a copy claim form to be given to the recipient by the physician at the time of service as a receipt. We anticipate that costs incurred as a result of the adoption of either of these proposals would be offset by savings realized from more truthful billings. Either procedure would build a sorely needed check and balance into the existing system.

With respect to pharmacies, the Commission is pleased to point out that a major step in reducing program costs was taken by the medicaid division during the pendency of our probe. Under present regulations, generic rather than brand drugs should be prescribed and dispensed whenever possible. Additional steps can be taken to further reduce abuse and unnecessary expenditure of limited program moneys.

Computer Information Needed

The State currently has the computer capability to develop a prescriber profile on medicaid program physicians. This program would analyze prescribing patterns of physicians and display questionable or abusive practices. Unfortunately, the profile is not effectively used because program providers choose not to supply necessary information on claim forms. We recommend that the State assume a tough stance on this issue and reject for payment any claims not containing relevant information.

To facilitate the gathering of information relevant to program integrity, we suggest that a standard medicaid multicopy prescription/claim form be developed. The name of the prescribing physician could be prestamped on the form. The physician should list the medication desired and draw a line immediately under the last item prescribed and personally sign the form. Space can also be provided for the physician to list a substantiating diagnosis. A copy can be kept for the physician's record and the balance forwarded to the pharmacy via the patient for use as a description of drugs to be dispensed and the pharmacist's billing invoice.

Existing program regulations prohibiting the referral of patients to a particular pharmacy by physicians should be broadened to encompass all facility employees and stringently enforced. It should be made clear to all that the physician may not require nor may he recommend that a prescription be filled by a particular pharmacy; nor may his receptionist or any employee do so. Patients who ask must be reminded of their free choice of pharmacy. Any liaison—including direct telephonic connection and common entranceway—between physician and pharmacist should at the very least create a presumption of impropriety and such relationships should be subjected to special scrutiny as to pharmaceutical utilization.

Landlord tenant relationships present perhaps the greatest temptation to over utilize pharmacy services. Even without direct steering by facility staff, patients are usually required to pass the pharmacy entrance to pick up coats or children before arriving at the public street. The in-house pharmacy truly has a captive audience. For this reason, the common entranceway should be prohibited. Moreover, when a physician or landlord owns a pharmacy or has a pharmacy for a tenant, he is induced to take whatever steps are necessary to see that the pharmacy succeeds. Inhouse pharmacies also present opportunity for profit based upon the precise nature of inventory kept and the ability to obtain volume discounts on drugs. We recommend that the State take these savings into consideration along with the fact that inhouse pharmacies primarily—if not exclusively—service patients of the facility and reimburse these pharmacies at a lower institutional pharmacy medicaid rate.

Mr. Chairman and distinguished members of the committee, thank you for your cooperation with the New Jersey State Commission of Investigation in its own probe of the medicaid program and for listening to me today. I will now attempt to answer any questions you may have.

Senator Moss. Thank you very much, Mr. Rodriguez, for your testimony and also for the report that you have provided for the committee, and it is being released just today. This report will be included in our record.[1] This is a very significant document that gives us a viewpoint of what is being done in New Jersey.

How large a staff do you have on S.C.I.?

Mr. Rodriguez. We have approximately 16 investigators, 4 attorneys, 4 accountants, 4 commissioners and an executive director.

Senator Moss. Do you find that staff to be adequate or is that pretty small?

More Investigators Needed

Mr. Rodriguez. Sir, when you have 16 investigators looking into a program of New Jersey that encompasses approximately $400 million, it is really not adequate. The men that we have are extremely qualified men, specially picked. They do a tremendous amount of work in uncovering the abuses in many of our programs. This is not the only investigation that has been conducted over the past 2 years.

Senator Moss. Our staff here tells us of the great cooperation that it received from you in New Jersey and they speak highly of your staff and the work you do. I was under the impression also that the volume of work to be covered was probably more than your personnel is able to cover adequately and that you were probably straining at the limits of what your staff could do.

Mr. Rodriguez. That is very true, sir, because while we were doing the medicaid investigation since 1975 we have reported on one phase of the nursing home and we have reported on the clinical phase, we are reporting on this phase today. We have another report being generated on the capitalization of nursing homes which is another massive abuse. Coming shortly is our report on the hospitals in New Jersey, and we have covered several of the other purveyors.

We keep a continuing eye on the movements of organized crime in New Jersey which is one of our main thrusts, and I think we have

[1] See appendix, p. 599.

received some credit for moving some of the top crime out of the State of New Jersey. We have to maintain a certain amount of our personnel constantly vigilant in other areas. The amount of work they have done, I would like to personally say today in public that is free for the taxpayers of the State of New Jersey and with the assistance of your investigators this will hopefully start a national trend that will save some of these billions that are being ripped off with not 1 cent going to the quality of medical care, it is just rip-off money so I don't like to hear statements of it is defensive medicine that is required. This is quality care money that is now being taken from the poor, it is rip-off money. I think these reports of your investigators clearly indicate that it is an abuse and it should be stopped as quickly as possible.

Senator Moss. Has the degree of cooperation been satisfactory with the State enforcement, legal prosecutors, State attorneys and whoever else does that work?

Mr. Rodriguez. When we submit information to them, many times the results are not forthcoming as quickly as we feel perhaps they might be. I don't believe that there has been a sufficient aggressive management by medical societies of the ethical problems that develop, but by and large New Jersey is or has been taking giant steps in trying to correct the situation, but much has to be done.

Senator Moss. Well, again let me say how very much we appreciate what you have done and what you have brought in to illustrate the type of investigation which was carried on in New Jersey. I think it is one of the bright spots we have uncovered in New Jersey, and Michigan probably will do more in attempting to adequately investigate and police these activities and other States, at least the ones that we are familiar with.

So we want to commend you for that and to offer you our continued cooperation. We hopefully can try to press forward on the Federal level to get better tools to deal with this. Basically law enforcement, this is the local level and it comes to licensing and inspection and criminal procedures so we need to depend on the strong arm of the States with your showing in New Jersey.

Mr. Rodriguez. Thank you, sir.

Indictments Needed

I would like to make one other point that many times our Commission feels through this method of public hearing and disclosing the abuses that it is not necessary for the integrity of the program to obtain an indictment here or there. I think when the proof is there they should be aggressively pursued of the indictment but what is more important is to bring to public light the abuse and the correction so that we don't constantly pay for the mistakes of the past but plug the hole in that pocket.

If we can obtain that objective, then I am willing, as our Commission does many times when it takes testimony and grants witness immunity for obtaining essential information for corrective action, that in the long run the taxpayers gain, and I think that is the main thing that hopefully will come from these hearings, the corrective action immediately, and then let the prosecution follow so that the rules are clear in the future. Then when you find a transgression, you must stamp on it as quickly as possible because it becomes symptomatic.

Senator Moss. Thank you very much. You state the proposition very well and we are pleased to have been able to work with you.

Senator Percy.

Senator Percy. Mr. Chairman, your testimony today confirms the findings of the subcommittee staff and it is good to have that verification.

Are there any types of medicaid fraud that exist in New York that do not exist in New Jersey?

Mr. Rodriguez. Well, New Jersey did not have the factoring problem that New York had but by and large we find that it is symptomatic. If you find it in New York, you will find it any place you have the medicaid program. Unfortunately I have to make that statement. I don't think we can write off any State that has a large amount of medicaid money flowing to it and say it does not exist in this State. I don't wish to point out New Jersey necessarily as being the culprit but I think we are symptomatic in the problem.

Senator Percy. Would it be fair to assume that, just like the kickbacks and payoffs in the aircraft industry, what developed to be a part of Lockheed happened to be adopted by various companies, and eventually spread like a cancer through the industry? Is this the kind of thing that is likely—if it starts some place—word is likely to get around that this is the way it is done? Does someone come up to New York and study how it is done so that we really kind of assume that if it exists there in New York and New Jersey, Illinois, California, and Michigan, it probably exists virtually any place in the country where you have large scale expenditures for medicare?

Uncovering Techniques Is Key

Mr. Rodriguez. I think that is a fair assumption.

Senator Percy. Finally, has the New Jersey Commission developed any techniques that can effectively curtail medicaid fraud and abuse activities that you could share with the public totally? Have you developed an approach that you think would be helpful and useful to us as we prepare to introduce legislation and offer amendments to it on the floor? Anything you can help us with, either now in your testimony or that you could furnish subsequently to the subcommittee, would be appreciated.

Mr. Rodriquez. First, as part of our statement we do make certain recommendations that we have made this morning to our legislature with respect to this phase of the program but we found, as we did in our clinical blood lab investigation, that there are certain techniques that you can uncover that once you uncover the technique it is only a matter of seeing its application in other phases of the program. The so-called ordering through medicaid, or ordering through a facility the dinner and then charging medicaid a la carte is one of the problems that we find in many areas where they can submit a blood test which we found in our clinical blood lab investigation.

The computer printout would read some 8 to 12 findings and for $3.50 this would be accomplished at one of the laboratories where one of the clinical labs dealing with medicaid would pay the $3.50 and then a la carte the blood test to medicaid and charge 12 times or 8

times. Well, that system we find is also uncovered when I made reference to the X–rays, when they were read each time or billed each time. Look at the right, look at the left, look at the lumbosacral joint. That is three readings when it is actually one plate. They don't charge each time the shutter snaps, they charge each time the eye focuses. So it is a matter of again going to the a la carte method of going to the X–ray plate. I think integrity dictates that when you are dealing with taxpayers money that you give them a little more consideration when you deal with that kind of fund.

I know the reference was made to performance, and we made some reference here when I concluded my testimony, but when I hear Mr. Halamandaris talk about $1.5 billion perhaps being ripped off nationally—in this phase alone New Jersey perhaps had $3 to $4 million ripped off—I think few taxpayers would refuse the Federal Government the thread to sew the hole in the pocket. Unfortunately, these things must be recommended and we recommend a modest example of it here.

Mr. Percy. Thank you very much, Mr. Rodriguez.

Senator Moss. This has been an exceptionally interesting and revealing morning of testimony and I think all of us understand the problem a little better now.

This will complete our hearings for today. We will meet again at 9:30 in the morning and we hope to be joined by Senator Talmadge and Senator Muskie.

We are now recessed.

[Whereupon, at 1 p.m., the subcommittee recessed, to reconvene at 9:30 a.m., Tuesday, August 31, 1976.]

APPENDIXES

Appendix 1

REPORT OF THE NEW JERSEY STATE COMMISSION OF INVESTIGATION ON THE PRACTICES AND PROCEDURES OF PRACTITIONER GROUPS PARTICIPATING IN THE NEW JERSEY MEDICAID PROGRAM, DATED AUGUST 30, 1976, SUBMITTED BY JOSEPH H. RODRIGUEZ [1]

Introduction and Summary

As part of its evaluative probe of the entire Medicaid program in New Jersey made at the request of Governor Brendan T. Byrne, the New Jersey State Commission of Investigation (S.C.I.) assigned one of three investigative teams to look into the area of health services encompassing providers of other than nursing home and hospital care. Among the major components of this section of the program are dentists and physicians practicing in groups or otherwise associated by virtue of sharing space at a common facility. The practitioner phase of the investigation focused upon the workings of individual medical facilities devoting at least 75% of their practice to Medicaid and bringing in substantial amounts of Medicaid money and the manner in which these facilities are administered by the New Jersey Division of Medical Assistance and Health Services (D.M.A.H.S.).

During the course of this investigation, staff of the Division's small Bureau of Medical Care Surveillance provided valuable assistance to the Commission. We wish to publicly express gratitude to Division Director Gerald Reilly and Surveillance Bureau Chief Boniface Damiano for extending many courtesies and total cooperation. The New Jersey State Commission of Investigation also established a working liaison with the United States Senate Select Committee on Aging which is reviewing the Medicaid program—a program under which Federal and State tax dollars are paid to providers of medical care for necessary services rendered to the indigent—on the National level.

Evidence obtained by the Commission on some twelve sample facilities is not sufficient to dispute statements that only a small minority of practitioner groups receiving substantial Medicaid monies engage in improper or questionable conduct. However, the Commission recognizes that the potential for the abuses outlined in this report is great and accordingly, the Commission is recommending the following steps to promote program integrity, guard against unnecessary utilization and ultimately, conserve State and Federal tax dollars.

The principal thrusts of these recommendations, which are reviewed in some detail subsequently in this report, are:

Promulgation of a scheme to identify and register on an annual basis, medical facilities receiving substantial amounts of Medicaid monies.

Periodic inspection of such facilities for proper procedures and cleanliness.

Outlawing percentage arrangements between facility owner-operators and practitioners.

Establishment of a liaison between the Division of Medical Assistance and Health Services and an insurance clearing house to obtain accurate information on payments made by insurance companies to physicians on behalf of Medicaid recipients.

Addition to the staff of the Bureau of Medical Care Surveillance of undercover agents who would pose as recipients seeking medical cases to ferret out:

[1] See statement, p. 588.

"Ping-ponging": Practice of requiring a patient to see several specialists in the same facility without medical need.

"Family-ganging": Practice under which covered family members are seen by facility personnel without initially requesting care.

"Churning": Practice of unnecessarily requiring patients to come to a facility for billable visits.

"Steering": Practice of directing patients to specific specialists or pharmacies.

Use of para-professionals; requirements to sign claim forms in blank.

Notification to recipients of services billed by physicians.

Require that physicians and radiologists justify the need for radiology procedures and holding both the requesting physician and radiologist separately and equally responsible for assuring that all requested procedures are consistent with the patient's diagnosis.

Outlaw direct telephonic links and common entranceways between medical facilities and pharmacies.

Reduction in Medicaid reimbursement rates to pharmacies sharing space in medical facilities.

Enforcement of State statutes prohibiting lay personnel from participating in the practice of medicine.

Medicaid Group Practice—Characteristics of New Jersey Mills

In connection with its evaluation of New Jersey's Medicaid Program, the Commission determined to examine the professional group-pharmacy aspect component for possible abuse. Scrutiny was centered upon the practices and procedures of relatively large dental and physician groups, their relationships with other providers of medical care and services—especially pharmacies—and the adequacy of existing regulations and integrity monitoring methods utilized by the Division of Medical Assistance and Health Services (D.M.A.H.S.).

The Commission focused upon recognized professional groups, "professional centers" housing various unassociated tenant practitioners and offices of single practitioners in which other physicians would regularly share space in either an employee or independent contractor capacity. More than twelve facilities across the State—each having at least a 75% volume of welfare patients and bringing in substantial Medicaid monies yearly—were examined. Books and records were reviewed, offices were visited by investigators posing as patients, and sworn testimony was taken from practioners, facility employees, Medicaid recipients and program administrators.

The facilities reviewed were located in poverty areas—Camden, Hoboken, Irvington, Jersey City, Newark, Passaic and Paterson—and housed in places such as welfare project high-rise buildings, converted stores, warehouses and tenements. Typically, the facilities were divided into a reception area for patients—some of which were equipped with rows of theater-type seats consistent with mass production technique—and several smaller compartments used for patient examination, X-ray services and laboratory services. Several locations also contained in-house pharmacies.

Each facility had an owner or the equivalent of a business manager to supervise the day-to-day running of the operation, hire and fire physician, nursing and clerical staff, and arrange liaison with out-of-house specialists and suppliers of goods and services. In many cases, the owner of business manager was a layman.

Arrangements are made between owner or administrator and physicians who desire to practice at the facility. In the main, staff practitioners were comprised of foreign physicians and recent graduates anxious to put together enough capital to open their own practice elsewhere. As one doctor told us of plans to stay at a medical center:

> I don't think I'd want to be involved with something so fly-by-night. My main attention is for my private practice, and when it's built up enough, this is where I want to be, in my private practice.
>
> Q. In the Passaic area you mean?
>
> A. No, in Englewood.

In earlier years (1971–1973) many facilities paid staff physicians a straight salary averaging only $15.00 per hour regardless of the number of patients seen or amount of services billed to Medicaid. A pharmacist who owned part of two facilities described early salary arrangements:

> Q. With reference to the salary arrangements at * * * Medical Center and when it was existing at the * * * Medical Center, were doctors permitted to bill, if you know? Were doctors permitted to bill Medicaid, for

instance, for services they performed, or would those monies accrue to the medical center?

A. Well, I'm—I'm sure that doctors filled out their forms and submitted it, but I'm quite sure the monies or the checks coming in from Medicaid or Medicare, whatever, were made out to * * * Medical Center. If that's what you're asking.

Q. Yes. Okay. In other words, what I'm really wondering is, did the doctors get anything more than $15 an hour?

A. No.

Salary arrangements between facility operators and staff practitioners declined because of a fear that such arrangements might subject facilities to the licensing and cost review requirements of the Health Care Facilities Planning Act, *N.J.S.A.* 26:2H–1, *et seq.* A center owner described the strategy:

Q. Do you know how the Doctors and other personnel at the center were hired?

A. When we first took over there was a salary basis. But then there seemed to creep up this certificate of need and we went to two meetings and it seemed as though if you were going to be an organization that hired physicians or opened a medical installation, you had to attain this certificate of need.

Q. From the Health Department?

A. Right. Well, being a nonprofessional. And at this meeting it became evident that they didn't like the idea of nonprofessionals in the medical business, so you had to either go—that idea was canned as far as salary, if you wanted to continue it, and at this point being involved financially I thought we would have to find another way. Then we decided to rent the premises to physicians and that's what we did. We rented the area to physicians.

Arrangements shifted to "rental" or "partnership" agreements based upon a percentage of the fees earned by the practitioner. The Commission identified specific relationships under which the amount kept by the practitioners varied from as little as 30% to as much as 70% less $100. On the average, practitioners involved in such arrangements turned over 40 to 50% of their earnings to facility operators or landlords. Typical negotiations with a lay landlord owner were described by a physician:

Q. Do you recall the substance of that interview; the offer, if any, that he would have made to you?

A. Well, he asked, you know—I told him that at the time I was looking for a job and I was going, you know—I would be interested in working in the clinic and he said he was looking for a general practitioner for his clinic and if I was interested, you know, I could—you could—you know, I could start working at his clinic on the exact day of opening. It was set at the time.

Q. And did you indicate to him that you were interested?

A. Well, I was interested very much to stay in that area because I had a lot of my own patients from * * * that I knew would follow me, and I didn't really want to move out of the area which was acceptable to all of my patients buswise and areawise and at the time I didn't feel very secure to—by myself, to open an office in the Newark area at that area where it was. So I felt it was a very good deal for me. I would still be seeing my patients; I would be in the same location and at the same time I had the security that I wasn't alone * * * practicing in, you know, in an area of Newark that is not really very safe.

Q. Did Mr. * * * suggest some type of financial arrangement or salary to you at your meeting with him?

A. Yes, we discussed that too.

Q. Can you give us the terms of the financial arrangements.

A. Yes. We discussed, and in his terms, I was to bring my knowledge and my stethoscope and he would provide me with space and telephone service, and, you know, all medication, nurses, secretarial work, everything, and so for that he would charge me a definite amount of fee.

Q. What was the definite amount of fee? Was it a percentage?

A. Well, the fee was—yes, it was 50 percent.

Q. How would the 50 percent reach Mr. * * *? Would you have to write a check or would he write a check to you after certain deductions would have been made?

A. I was to write him a check.

Q. Would you bill Medicaid under your own name?
A. Yes, sir, I billed Medicaid in my own name.
Q. Then after you received a check from Medicaid.
A. Yes.
Q. —would you then just take half that?
A. Yes. I would write him a check for half of the amount that was paid to me.
Q. Did Mr. * * * require any type of proof from you as to the amount of money that Medicaid had paid you?
A. All the billing that came to—through * * * and there was a secretary——
Q. I see.
A. —who kept track of it.

The presence of the operator-owner's secretary to keep a watchful eye on billings was not at all uncommon.

Facility administrators contend that the high percentage return to the center is justified by the space utilized by staff practitioners—including all common areas—and expenses including salary of nursing and secretarial personnel as well as other operating costs. The Commission recognizes that certain expenses are indeed borne by the facility, but suggests that economies of scale accruing to large facilities should lessen the necessity of high percentage arrangements. We believe that these percentage arrangements lead to unreasonable profit for facility owner/operators and foster abuses which will be detailed later in this report.

More recently, arrangements between facilities and staff have involved fixed payments which increase with growth of practice. At one facility, a lay owner-operator charged a specialist $500 per month. On its face, the fee did not appear high. The physician went on to testify that he was present at the facility only two days a week.

Q. Can you tell us who the principals in the * * * Medical Center might be?
A. Mr. * * *.
Q. Could you classify him as owner or an operator or——
A. He's owner of the building, I think. I don't know. He owns * * * Medical Center. That's his.
Q. Is there one physician who might be in residence at the * * * Medical Center more than anyone else?
A. I can't answer. I'm there two days.
Q. Is there a physician who might be a director of the center?
A. No.
Q. No. Would you know which physician might be at the center more than two days?
A. I don't think anybody is.
Q. How much rent do you pay to the * * * Medical Center?
A. * * * and I worked out an arrangement that I have to pay the equivalent of $500 a month.

As the physician indicated, he was not the only physician who practiced at the center on a part-time basis. The Commission questioned the owner-operator about his costs and other arrangements at the center. It came to light that he leased the entire building for only $225 per month and had "arrangements" returning much more:

Q. You're paying $225 a month for the floor to * * *?
A. Right, sir.
Q. How much rental do you get? Or any company that you are principal in, what do they get in rent a month?
A. Several thousand dollars. I can't give you an exact number.
Q. So you're taking in several thousand dollars a month as a landlord, correct?
A. Right, sir.

At another facility, a building was leased for $500 per month by a physician. He himself practiced there, and sublet space to dentists for $200 per month and to a physician specialist for $550 per *week*.

At yet another center, physicians paid the lay-owner operator a weekly fee.

Q. How do you determine how much rent a particular doctor in one of your offices should pay?
A. Well, they are—the full time doctors, they paid $300, you know.

Q. Is that a month or a week?

A. This is a week. It depends upon also the medicines and supplies that they use.

Q. So it would be like a flat fee plus the cost of whatever materials they use; is that right?

A. Yes.

Pharmacies also have arrangements with medical facilities. At one medical group, a pharmacy paid in excess of $1050 per month rent for some 225 square feet of space. It is significant to note that the rental increased from $550 to $850 to its present amount within two years and without any concomitant increase in space.

Several of these facilities were visited by investigators from the State Commission of Investigation and the United States Senate Special Committee on Aging. In many cases, investigators reported filthy conditions and questionable and fraudulent practices by employees which will be detailed throughout this report. Our experience with these facilities, as partly set out in this document, demonstrates the need for a new approach by the Division of Medical Assistance and Health Services.

Initially, we recommend that facilities receiving substantial Medicaid monies and having several staff practitioners be identified, registered and periodically inspected for proper procedures and cleanliness. We believe that the Division of Medical Assistance and Health Services presently has power to promulgate an administrative scheme to accomplish this purpose. During the course of the Commission's investigation the Division drafted such a scheme and we add our support to it. We suggest, however, that a more effective solution might be to amend existing State health facility licensing law (*N.J.S.A.*26:2H–1 *et seq.*)—the very law which facility operators now seek to evade—to provide for Health Department jurisdiction irrespective of the nature of the financial arrangements between owner-operators and staff over these facilities which receive substantial amounts of taxpayer dollars. We note that such a statutory amendment would also place in the Health Department power to review and set reasonable rates of reimbursement for these facilities which, hopefully, would be more in keeping with the goals of a public welfare program rather than private profit motive.

Percentage arrangements in a Medicaid setting should be outlawed. As this report will indicate, they are incompatible with the goal of providing quality care to recipients at reasonable cost to taxpayers. Such arrangements foster and incite over-utilization of services, ping-ponging, family ganging and churning. It is unrealistic to expect practitioners to practice fiscal restraint when salary is dependent upon the amount billed.

We further urge that an identification system be developed to indicate on the claim form which specific practitioner rendered service to the recipient and the precise location where the service was rendered. Such information—which is not now readily available—will provide program surveillance personnel with easy access to accurate information on monies flowing through particular locations and facilitate detection of ping ponging, and family ganging.

It will also track Medicaid Doctors who wander from facility to facility. The Commission discovered one physician who visited three facilities in different cities a week. Such a practice raises serious questions about continuity of care and treating physician availability to patients.

The testimony also raises serious questions about possible violations of the Professional Practices Act (*N.J.S.A.*45:9–1 *et seq.*) by facility lay owner-operators who share in the profits of facility associated physicians. The Commission will forward a copy of its investigative record to the State Board of Medical Examiners for consideration of this and other issues.

Affiliated Radiology Services

Once the treating physician determines radiologic services are necessary, a requisition specifying the X-ray procedure desired is drawn. The service may be rendered in one of several ways: The patient can be referred to a specific radiologist or hospital facility; the X-rays can be taken, developed and "read" by a radiologist member of the group using his own equipment and personnel; films can be taken on the group's equipment by a technician paid by the group and interpreted by the radiologist whose office may be located off the group's premises.

Ideally, in this latter situation, the radiologist will closely supervise the work of the X-ray technician and will himself perform (or be present for) more esoteric

procedures. During the course of the investigation, however, the Commission discovered one instance where a radiologist receiving in excess of $118,000 of Medicaid funds between 1972 and 1975 was employed full time at a New York hospital. Despite the fact that Medicaid claim forms signed in his name represented that the radiologic services, including intravenous pyleography, mammography and tomography, "were personally rendered" by him or by a qualified individual in his actual presence, office employees—including the X-ray technician—saw him only once or twice over the years. In the absence of the radiologist, numerous X-rays of questionable medical value were ordered by office physicians and taken by the technician. The radiologist could only review medical necessity on an after the fact basis and, according to the X-ray technician, would question the number of films taken on individual patients:

Q. All right; but what would he say, for instance?
A. Why was an X-ray taken? Or, why was this taken?
Q. He would ask you?
A. Yes.
Q. Would he ask anyone else?
A. No.
Q. Did he sound sort of complaining when he would ask you?
A. I don't know what you mean, complaining.
Q. Well—
A. That I shouldn't do it?
Q. Yes.
A. I don't know. He would ask me why did I take it.
Q. I'm sorry. I missed the last part of that.
A. He would ask me why did I take it.
Q. Okay. And you would say what?
A. Because I was told to take it.

The testimony raises serious questions about the quality of care received by office Medicaid patients in this highly sensitive and potentially dangerous area of health care delivery. The record also raises questions about the conduct of certain physicians which appears to transgress basic standards of medical ethics in practice, issues which are beyond the scope of this report.

At another facility, with the radiologist located in a nearby city, evidence exists that unqualified persons were permitted to take X-rays. Rather than hire a licensed X-ray technician, the lay group administrator allegedly instructed a licensed practical nurse (LPN) to take films. If questioned by authorities concerning X-ray procedures, group personnel were supposedly rehearsed to claim that the LPN only positioned the patient and that a physician actually "pushed the button". Questions concerning these allegations to a physician-partner of the group drew the following responses:

EXAMINATION BY COMMISSIONER LUCAS

Q. During your stay at * * * Health Group was there an employee of the health group by the name of Sonia?
A. Yes.
Q. And do you know how long Sonia was with the group?
A. I'd say about a year.
Q. All right. Do you know what her duties were; that is, were they administrative as opposed to medical?
A. I plead the Fifth and Fourteenth Amendments.
Q. Did Sonia dress in the garb of a nurse?
A. I plead the Fifth and Fourteenth Amendments.
Q. Do you recall if Sonia dressed in the garb of a lay person in the office of a doctor?
A. I plead the Fifth and Fourteenth.

* * * * * * *

Q. All right. Now, in the spring of 1974 was there an X-ray technician—strike that.
In the spring of 1974 was there a young lady at the * * * Health Group by the name of Sonia, who would take X-rays?
[Whereupon, the witness confers with counsel.]
A. I plead the Fifth and Fourteenth Amendments.
Q. Do you know if—strike that.
Do you know whether or not Sonia was a certified X-ray technician?
A. I plead the Fifth and Fourteenth.

Q. Did you ever hear * * * instruct physicians to say that they, the physicians, rather than Sonia took X-rays if anyone should ask?

A. I plead the Fifth and Fourteenth Amendments.

After the group obtained the services of a licensed technician, problems again developed when the facility's lay administrator himself allegedly took X-rays. The physician-partner again raised constitutional privileges when asked if it was ever brought to her attention that the administrator may have taken X-rays. The administrator denied taking X-rays but acknowledged that he could position patients and develop X-rays for a physician who would "push the button".

Radiologists associated with Medicaid Mills, like other practitioners, often work on a percentage fee arrangement. The Commission commonly found group associated radiologists keeping only between 35–40% of Medicaid dollars paid for radiology services with the balance flowing to the facility. Other situations were encountered in which the radiologist would pay the group a lower fixed percentage of his fees plus a monthly rental. (30% of fees plus $100/month is one example of this type arrangement.)

In any percentage relationship, incentive exists to increase dollars received by increasing volume of work performed. The radiologist can maximize his income by billing for as many procedures as possible on each patient. The group can maximize its earnings by supplying as many patients as possible to the radiologist through the practice of "ping-ponging". These temptations often materialize in pressure exerted upon group physicians to order unnecessary X-rays for their patients and radiologists engaging in "creative billing"—billing based upon the number of readings rather than the number of anatomic areas filmed—and false billing for services not performed.

In one mill administered by a layman, a pediatrician preferred to use the services of a radiologist in whom she had "tremendous confidence" rather than the radiologist associated with the facility. The landlord-administrator chided the pediatrician for referring patients to outsiders and suggested that the Mill's radiologist—who paid the landlord a percentage of his fees plus a fixed amount monthly—should be utilized.

Q. Did Mr. * * * ever tell you why he wanted you to use Dr. * * * rather than another radiologist who might be outside the group?

A. He felt that the medical center would make more money if we used our own and he installed the machines and went into the expense to put everything, that we should utilize what we have in the clinic.

At another group where the radiologists received 40% of the Medicaid fees for radiology services, a physician complained the lay administrator would approach him with respect to specific patients and ask, "You're going to order X-rays, aren't you?" On other occasions he was chastised by a physician partner for allowing a patient to have X-ray services performed at a near-by hospital rather than at the group.

* * * * * * *

I remember the incident, Dr. * * * called me aside and said to me, "Why did the patient have the X-rays done at St. Michael's?" I don't remember if it was an upper G.I. series. It possibly was and/or a chest X-ray. But I was taken aback by her and I said, "* * *." I said, "the form that I used for the requisition for the X-ray for the patient was to have it taken at the office of a radiologist, and the hospital has a very similar requisition and the patient can go any place he wants for that X-ray." She says, "Well, we offer the service here. Why didn't you have it done here?" I said, "* * *, the patient had the X-ray done at St. Michael's. I'm only interested that the patient had the X-ray procedure done, not where she had it done." But she was very, very angry with me and I controlled myself * * *

* * * * * * *

When questioned about pressures exerted by the lay group administrator on physicians to take numerous X-rays, a physician partner responded:

* * * * * * *

Did Mr. * * * ever suggest to you that you yourself should order a certain number of X-rays on your patients?

[Whereupon, the witness confers with counsel.]

A. I respectfully plead the Fifth and Fourteenth Amendments and decline to answer the question on the ground that the answer may tend to incriminate me.

The CHAIRMAN. Doctor, in the event we have occasion to rely on those privileges again, the record will indicate the complete context of your statement, but you would simply have to say you plead the Fifth and Fourteenth Amendments. All right? Instead of going through the entire process.

The WITNESS. Fine.

Q. Doctor, are you aware of any advice or suggestions that Mr. * * * may have given to other physicians at the * * * Health Group concerning the number of X-rays they should order for their patients?

A. I plead the Fifth and Fourteenth Amendments.

* * * * * * *

The radiologist associated with the group maximized his percentage earnings by billing Medicaid for an additional esophogram whenever the group X-ray technician would perform an upper G.I. series and even though the treating physician would not request such a procedure. The X-ray technician testified that he only took films for an upper G.I. series and forwarded a Medicaid claim form to the radiologist which billed only for the procedures he actually performed:

A. I would do a GI series and that would be all. And then one morning I noticed the forms were on the counter and then underneath it, the GI series, and in another person's handwriting "and esophagus," and it had a certain amount of money written on the side.

Q. So "and esophagus" was added in?

A. Right.

Q. You didn't do anything to the esophagus?

A. No.

Q. Right?

A. No.

Q. Who signed the form, do you know?

A. Dr. * * * [the radiologist].

Q. Are you sure?

A. Yes.

Q. Were the words "and esophagus" written in the same color pen as Doctor * * * (radiologist) signature? Did you notice that?

A. Right, yes.

Q. It was. All right. How many times did this happen, often?

A. On practically every G.I. series.

This technician was also instructed by the radiologist to take films other than those requested by the treating physician:

Q. Okay. Did anyone ever tell you or suggest to you that, as the X-ray technician, you should do more X-rays than the X-rays requested by the physician?

A. Right, Doctor * * * [radiologist].

Q. Doctor * * * [radiologist]. What did Dr. * * * say?

A. Doctor * * * requested that if it was a finger, that I would do a full hand on the frame.

Q. Did he tell you why you should do a full hand?

A. No.

Q. He just said do it?

A. Right.

Q. And this is even though the prescription or the written request that you would get from the doctor requesting the X-ray would say the finger?

A. Right.

Q. What would you do, the finger or the full hands?

A. I would do the full hand.

Q. Any other particulars, such as a foot, ankle?

The WITNESS. Yeah. He said if it was an ankle I was to do a foot and ankle.

Q. Right. In other words, if the request said please X-ray right hip—

A. I was to do both hips.

Q. In other words, if the request said please X-ray right hip, you would do both hips?

A. Both hips.

Q. Do you know why doctor would make that request—Doctor * * * [radiologist]?

A. Just for a comparison. But most comparison studies are done between children under sixteen.

Q. And you say children under sixteen. Were most of these hips X-rays taken of children?

A. Not really.

When questioned concerning the practice of the affiliated radiologist to engage in "creative billing", the physician partner invoked the Fifth Amendment.

Steps can be taken to safeguard the program from overutilization of X-ray services and "creative billing". Primary physicians requesting radiologic procedures should be required to document *clearly* the medical necessity of such procedures in the patient's chart. The requesting physician should then specify the precise X-ray procedure desired on a multi-copy combination Medicaid X-ray requisition claim form. A line should be drawn under the last test required and immediately thereunder the requesting physician should list the diagnosis and "rule-outs" for the benefit of the consulting radiologist and Medicaid surveillance personnel. The requesting physician should then personally sign the form and forward it to the radiology consultant for use as a description of services to be rendered and as his own program billing invoice. Both the requesting physician and the radiologist should be separately and equally responsible for assuring that all requested procedures are consistent with the patient's diagnosis. If a radiologist believes that services requested should be modified, extended, or rejected, he should be required to consult with the requesting physician. Claims not submitted in complete accord with the above procedure, should be rejected by the processing agent.

Steps should be taken to make it clear to providers that radiology billing should be based on the number of anatomic areas filmed rather than on the number of readings. While for example, a pelvic film allows interpretation of multiple anatomic segments, a radiologist should not bill for readings of "right hip," "left hip", "pelvic", lumbosacral spine", etc. Only the minimum number of views necessary to delineate anatomic pathology should be taken.

The Commission also suggests that the Division of Medical Assistance and Health Services give serious consideration to the amount and method of reimbursement to program radiological providers. The fact that many providers are willing to accept 35–40% of the present Medicaid fee itself suggests that the fee may be high. 60–65% of that fee, or the portion taken by the group, may contain excess profit in addition to monies sufficient to cover costs related to radiological procedures. The Division may well decide to adopt a method similar to that now utilized by New York City whereby one fee is paid to the radiologist for X-ray interpretation and another to the entity which owns and operates the equipment.

Not Getting Our Money's Worth

The Commission's investigation disclosed a number of practices used by physicians to maximize unfairly the amount of Medicaid reimbursement they receve. Many of these practices contravene the requirement (*N.J.A.C.* 10:54–1.1) that reimbursable services be rendered by the physician or in his actual presence:

"Physician's services" means those services provided within the scope of practice of the profession as defined by the Laws of New Jersey, or if in practice in another state by the laws of that state, by or under the direct personal supervision of an individual licensed by the State of New Jersey to practice medicine or osteopathy. It includes services furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere. Direct personal supervision means that the services must be rendered in the physician's presence.

One method of maximizing Medicaid income is to disguise non-reimbursable treatment through the use of codes applicable to reimbursable procedures. Medicaid pays for physical therapy under certain conditions. Payments are not made for "physical medicine procedures administered by a physician, or physical therapy which is purely palliative such as the application of heat *per se* in any form, massage, routine calisthenics or group exercises, assistance in any actiivty or use of a simple mechanical device not requiring the special skill of a qualified physical therapist." *N.J.A.C.* 10:54–1.7.

At one facility, patients were scheduled to come in for diathermy, hydroculator and electric muscle stimulator (E.M.S.) treatments at a time when the physician was not in the office. A facility clerical employee who operated the equipment testified as follows:

Q. I see. Now, would you run this EMS and hot pack machine when Dr. * * * was not in the office?

A. Sure. That's when we used it. We used it mostly in the morning because when he came in he had patients to see, and, you know, if we had a

patient in there taking treatment it would tie the room up and we needed the room. So we advised most of the patients to come in the morning for their treatment.

Q. I see. What about the EKG. Now, was this another situation where an EKG would be taken in the morning when Dr. * * * would be absent?

A. Yes.

Q. Was that standard procedure?

A. Yes, because it took time and it was also done in the same room and that took time to do also.

Q. Is all this equipment that we are talking about located in the one room?

A. Yes.

Q. And is this room also used for the examination of patients?

A. Yes.

Q. I see. So that any patients who would require treatments from these various electronic devices would be handled in the morning?

A. Yes, because if they came when he was seeing patients they would tie up that room for like ten or fifteen minutes and we only have four examination rooms to work with.

The clerical employee often "treated" as many as 30 patients per day out of the physician's presence.

Medicaid claim forms were submitted for these services in the name of the physician. The services rendered were described as "prolonged office visit" and processed for payment by the fiscal intermediary. The facility's registered nurse, who handled much of the Medicaid billing, testified as follows:

Q. When would you write prolonged office visit?

A. Whenever we give a physical therapy treatment.

Q. But, again, the physical therapy treatment might be diathermy?

A. Diathermy, EMS, EMS and hot packs, hot packs.

Q. So in your own mind were all these words and descriptions synonymous, they all meant the same?

A. No, because the diathermy machine is a different machine than the electro—electro-muscle stimulator machine.

The WITNESS. Did you get that lisp in there?

Q. No. But the prolonged office visit category, okay, would be used sometimes at least when physical therapy services would be rendered?

A. Would be used all the time when physical therapy service is rendered.

Q. All the time?

A. Yes.

The women who operated the physical therapy equipment and also gave injections, had no medical training. One of them testified concerning her background as follows:

Q. Are you a registered nurse?

A. No.

Q. Are you an L.P.N. or practical nurse?

A. No.

Q. Do you have any kind of training in the medical field?

A. I'm a medical secretary by training.

Q. And where were you trained?

A. Lyon's Educational Center, 900 Broad Street, Newark, New Jersey.

Q. And how long did you attend Lyon's? How long did you study there?

A. It was a year.

Q. Did you receive some sort of certificate—

A. Yes.

Q. —or diploma?

A. Yes, a thousand hours.

Q. And generally what kind of training did you receive there? What did they teach you?

A. Well, medical terminology. I had shorthand already in school, so I had shorthand, medical office procedures. I had typing. I imagine that's about it. English.

Q. Did you learn to operate any type of office equipment at Lyon's, any medical equipment?

A. No.

Q. Like a diathermy machine?

A. No.

Q. Did you learn how to give injections at Lyon's?

A. No.

Q. Did you learn how to take blood from a patient at Lyon's?
A. No.

She went on to detail the methods she used to give electric muscle stimulation treatments:

Q. What's a EMS and hot packs?
A. Electrical muscle stimulation. That was part of that machine. It was just like—I never knew heads or tails what it did. I was just told that's the way I had to do it. You just put the lotion on and you just iron; give him certain amount of watts. You ask him if he feels it. If he feel it, then you just leave him there and iron him for ten minutes. Just rub him back and forth.
Q. And did Dr. * * * leave you instructions as to what degree of voltage you should use with each patient?
A. Well, he showed me a couple of times and he said you would normally leave it on—like it was just a knob and it has numbers from one through eight, and like I used to put it midway, somewhere between four, five and six, you know, unless the patient said it was too much. Then I would turn it down. That's all.

One must seriously question the quality and value of these services.

Another abuse involved billing Medicaid for injections administered by a nurse or clerical assistant rather than the physician under the guise of an office visit. A registered nurse testified as follows:

Q. You mentioned earlier you gave injections, right?
A. Yes.
Q. Suppose the patient came in for an injection and you actually gave the injection. Would you fill out a Medicaid form——
A. Yes.
Q. [Continuing]. If the patient were a Medicaid patient? All right. And would you sign it in Doctor * * * name?
A. Yes. When a patient comes in for an injection and walks in the door, it's an injection that Doctor * * * has said, "Mrs. Jones, you come here each week for an Imferon injection each week and she comes for an injection.

The nurse claimed that in addition to giving the injection, she would check the patient's weight and blood pressure and ask questions about general well-being. Again, the services billed were not rendered by the physician although claims were submitted in his name.

Medicaid was also billed for office visits when patients telephoned the facility for prescription renewals. Often the decision to renew the medication would not even be made by a physician but by a nurse or clerical assistant. The nurse explained her procedure when a call from a patient was referred to her by the receptionist:

Q. Suppose she gave it to you, what would you do?
A. I check the patient's chart.
Q. Then what would you do?
A. See when her last visit was. If it was somebody who I was familiar with and her medications were normally renewed, they would be renewed. If it was somebody I was not familiar with or if she hadn't been there for a long time, I'd have her come in or I would hand it over to Dr. * * *.

In addition to the nurse, clerical personnel in the office renewed prescriptions. Instructions from the physician called for a Medicaid claim to be submitted in these situations. The medical secretary testified as follows:

A. Yeah. A lot of times I would go ahead and refill it and I would tell the patient, you know, you would have to come in and see Doctor some time this week.
Q. Okay.
A. Nine out of ten they would never show.
Q. What would happen as far as someone filling out a Medicaid form based upon my telephone call?
A. You see, I never did it. But it has——
Q. Would (the nurse)?
A. Yes.
Q. Well, what were her procedures? Would you make a list?
A. Doctor would tell—if Doctor was there and I told him a patient called and wanted meds renewed and I renewed it already, he had said get a form

and fill it out. Any one of us could do that. Just fill out the top part, the name and Medicaid number. We would hand it over to him or (the nurse) and they would take it from there.

* * * * * * *

Q. But the Medicaid form that's filled out is based upon the telephone call?

A. Right.

Q. Right. Not the patient coming in to see the Doctor?

A. Right.

Q. Right, Okay. Do you know what procedure code—you know what a procedure code is——

A. Yeah.

Q. [Continuing]. in Medicaid?

A. Um-hum.

Q. Do you know what procedure code is placed in or on that Medicaid form?

A. Triple o-one.

Q. Triple o-one means what to you?

A. Just a regular office visit.

A related problem involved instructions giving by facility employees to patients who would call in for prescription renewals. The receptionist described her procedures which were geared to getting the patient into the office for a billable visit:

Q. Have you ever answered the phone and gotten people on the other end who want to renew their prescriptions?

A. Yes.

Q. Well, what did you do? What is your procedure when that happens?

A. Well, I usually tell them to come down and talk to Dr. * * * about it.

Q. You ask them to come in in person?

A. Yeah.

Q. What would you say to them? Suppose I were the patient. What would you say to me?

A. Well, say, you know, you better come down to the office and bring your bottles, you know, the empty bottles and talk to him. If he can renew it, then he'll give it to you. If not, you know, whatever he says.

This is one example of techniques which we label as "churning" or unnecessarily requiring patients to come into a facility for a billable visit. A medical secretary at one facility described another technique:

Q. Was there any practice or procedure that you were aware of on the part of the doctor or anyone else in the office acting under his instructions to get patients to come back on any type of a regular basis?

A. I don't understand what you mean.

Q. Well, for instance, did Dr. * * * ever instruct you or the receptionist or any other persons working in the office to instruct the patients to return next week or the week after——

A. Yes, me.

Q. [Continuing]. to—all right. How would that work? What would his instructions be like?

A. Well, he would see a patient and say the patient had a cold, So he would say tell her I would want to see her Wednesday or Thursday. If they came in on Monday, tell her to come back Wednesday or Thursday to see me.

Q. And would the doctor actually examine these patients when they came back the second time?

A. He would come in and say, you know, "How do you feel?" you know, "How's the medicine working?" And they would say, "Okay." He would say, "Finish up your medicine and come back and see me again." That's what he would say.

Q. So he would want them to come back a third time?

A. Yeah. A lot of them came back three times a week.

Q. Three times a week?

A. (The witness nods her head.)

Q. What would happen the third time?

A. The same thing. He would come in and say, "How do you feel?" You know, "Cold all gone?" and they would say "Yeah." "Okay. Take it easy." And that was it.

Q. Okay. But there wouldn't be any further physical examination?
A. No.
Q. On his part?
A. No.

Another abuse involved billing medicaid *and* an insurance company for services rendered to recipients in connection with auto accidents or workmen's compensation claims. Medicaid claim forms presently ask the following questions:

8. Was patient's illness or injury connected with his employment? Yes/No
If yes, give name and address of employer here.
10. Did injury result from automobile accident? Yes/No

The fiscal intermediaries depend on accurate and truthful responses to these questions in determining whether treatment for certain conditions is reimbursable under the program. At one facility, these sections purposefully would be left blank. The fiscal intermediary processed the claims in this condition rather than rejecting them, and Medicaid was billed and paid for services which would also be billed and paid by an insurance company. The medical assistant/secretary testified as follows:

Q. Do you know of any instances where patients who were involved in accidents received payments from the insurance company or an insurance company and some of these payments from the insurance company went to Dr. * * *?
A. Yes.
Q. But Medicaid was also billed for services that Dr. * * * rendered to these patients?
A. Yes.
Q. What can you tell us about that type of a situation? How would that work?
A. Well, that patient—we had an invoice card on the patients. So whenever they came in, we would put down the date and at the end of the twenty-five or thirty treatments, you know, the secretary would type the bill up and send it into the lawyer. Meanwhile, if they were on Medicaid, we still had to fill out a form and submit the form to Medicaid. That's all.
Q. Do you recall any specific names of patients where this happened?
A. Yes.

Because of this rule, Medicaid monies could not only be paid to the physician, but also to pharmacies, laboratories and other providers of care.

The Division should take a hard stand with respect to this double billing. Any physician submitting claims to Medicaid who also claims reimbursement for identical services from another third party payer should be immediately and permanently suspended from the program.

We further suggest that appropriate State and Federal agencies consider such conduct in connection with possible actions against professional licenses and criminal sanctions.

Rather than relying upon the accuracy of information provided on the claim sheets or the good faith of hospitals or physicians in notifying Medicaid of any inquiries indicating the existence of an insurance claim, we suggest that the Division consider establishing a liaison with a local insurance clearing house. During the course of the investigation the Commission subpoenaed one such clearing house for information relevant to Medicaid recipients treated by suspect physicians for "trauma." The clearing house was quickly able to provide details of treatment and insurance company payments for which Medicaid was also billed.

Other common abuses include ping-ponging—the practice whereby a Medicaid recipient will be seen by many or all practitioners in a clinic, and family ganging—the practice under which covered family members of the patient are seen by facility personnel without initially requesting medical care. "Family ganging" often occurs when small children accompany a "Medicaid mom" to a facility.

A medical secretary described the procedure at one office:

Q. All right. Did Dr. * * * himself or did Dr. * * * instruct personnel in his office to try to get patients to bring their children in to him?
A. Well, no. He would ask the patient when they were there—you know, if the mother had the child with her, he would, you know, ask her if, you know, the child had all his baby shots. That's what he hit them with most, the baby shot bit. And she would say no or something and he would say get a form, fill out a chart and then we would start with the baby.

Q. And the mother would return with the baby to get the shots?
A. Um-hum.
Q. And who would give the shots?
A. Me.
Q. You would. Would the Doctor see the baby?
A. No, not unless the baby was sick.

At one facility, ping-ponging to the Dentist-tenant was common.

Q. And do you know who would, if anyone, make suggestions to the patients that the dentist be seen?
A. Usually Dr. * * *.
Q. Did he ever make that suggestion in front of you?
A. Yes.
Q. What would he say?
A. Your teeth look bad. I want you to see the dentist.
Q. And would he then escort them to the dentist's office?
A. Yes, most of the times he would.

Another employee corroborated ping-ponging to the dentists:

Q. Were there any other medical personnel associated with Dr. * * *? How about dentists?
A. Dr. * * * and Dr. * * *.
Q. All right. And would they come to Dr. * * * office?
A. The office was right behind us. All we had to do is walk through a hall.
Q. And were these two dentists in every day?
A. Yes, well, they would take turns.
Q. I see. One of them would be present every day?
A. Yeah.
Q. And how did Dr. * * * refer people to the dentist? Strike that question. Did Dr. * * * refer his patients to the dentists?
A. Yes.
Q. How would that happen?
Q. He would look at their mouths, you know, and like he would just ask them, "When was the last time you saw a dentist?" And he would send them right over to them.
Q. Would this be the same day that Dr. * * * saw the patient?
A. Yeah.
Q. He would send them to the dentist?
A. Yeah.
Q. Would the dentist then do something?
A. Take it from there.

At another facility a physician was pressured by the lay owner to refer patients to other in-house facilities, even for procedures which did not require services of a specialist:

Q. All right. Can you give us an idea of the nature of his advice; what did he suggest or advise you to do?
A. To have, for example, breast screening done on more female patients over age thirty.
Q. This would have entailed the services of the radiologist?
A. Yes.
Q. On the premises?
A. Yes.
Q. Possibly it was Dr. * * *?
A. Yes.
Q. All right, any other advice concerning what might be done with the patients or for the patients?
A. Well, that, for example, I shouldn't be—while there was available a GYN man on the premises that I should utilize his services.
Q. And was this the suggestion to you to utilize the service of the GYN man in connection with some specialized service that only a GYN man could render?
A. No. The pap smears I presume could be done by a general practitioner as well.

This facility was visited by investigators from the New Jersey State Commission of Investigation and the United States Senate Select Committee on Aging who posed as Medicaid recipients. Each of the three "patients" was greeted by a receptionist who extolled the merits of the facility and the various specialists

who practiced there. Before each of the investigators was examined or even seen by a physician, the receptionist made appointments for return visits with the dermatologist, radiologist, podiatrist, gynecologist, optometrist and dentist.

At another medical group a physician described pressures to ping-pong exerted by the lay administrator.

Q. It started——

A. When the Group got downstairs which was approximately May of '74 and the new office suites were ready and the dentist had then come in the area and there was an optometrist there part time and then the optometry office was on the side of the clinic. When we got downstairs, I was told to make referrals to the dentist, to the optometrist, to the obstetrician, to the gynecologist and also with the orthopedic doctor who was coming in eventually. And my answer at that time, I recall, to Mr. * * * was that if I think it's medically necessary for this patient to be seen by the dentist, I will tell him to go to a dentist, but I will not tell him to go to your dentist. I will not tell him to go to this eye doctor or that eye doctor. I will ask him when was the last time your vision was checked and examine eyes, which is a normal part of my routine exam.

* * * * * * *

Q. Okay. Now, you have indicated to us that Mr. * * * approached you with suggestions that you make referrals to certain of the other physicians in the group?

A. That's right.

Q. Are you aware of Mr. * * * or anyone else approaching other physicians and making a similar request for referrals?

A. Yes. I know that he was quite frequently harassing. I'll use the word harassing, Dr. * * * to make referrals to the gynecologist and eye, ear, nose and throat specialist or an orthopedic doctor.

* * * * * * *

Q. Do you have any idea why he requested the referrals to be made?

A. I assume that he was looking to ping pong his patients. That's an assumption—a presumption on my part, and that he was going to get a percent of the billing from the particular consultant, which would increase his income, certainly not mine.

The physician claimed that these pressures were one reason which caused him to disassociate himself from the group. The administrator involved allegedly referred to group patients as "warm bodies" and urged physician staffers to "keep the warm bodies flowing" ("ping-pong"). A physician partner was questioned about the activity of the lay administrator:

Q. Doctor, have you ever heard Mr. * * * use the term "warm bodies" in connection with the patients at * * * Health Group?

A. I plead the Fifth and Fourteenth Amendments.

Q. Doctor, have you ever heard Mr. * * * suggest to physicians at the * * * Health Group that they should circulate the warm bodies amongst themselves?

A. I plead the Fifth and Fourteenth Amendments.

The lay administrator's actions apparently did not end at advising physicians how to practice medicine. One female Medicaid recipient told of being examined at the facility by a "physician who did not wear a white coat."

Q. What did this man, this person do? Did he examine you?

A. He examined me with that thing around his neck. With it up here. The thing that you put on your ears and hangs on your neck.

Q. Did he listen to your heart?

A. He put it in a lot of places and in back and in front.

Q. Do you remember what he told you or did he tell you anything?

A. No, he didn't say anything to me.

Q. Did you tell him you felt sick?

A. Yes, I did.

Q. And then he examined you with a stethoscope?

A. Um-hum.

Q. Now, let's go back to when this person examined you, okay? Did he ask you to open your mouth and say ah?

A. He put something in my mouth and looked into my throat and he just examined my throat and then he gave me the pills.

Q. But he listened to your body with an instrument, didn't he, besides examining your throat?

A. Yeah.

The INTERPRETER. She doesn't know——

A. I don't know the name of the instrument he used, but he put it in his ears and examined my back and front and all over.

Q. When he was examining you with this instrument, did he tell you to breathe in and out deeply?

A. Yes, he told me to breathe deeply.

Q. When he was examining you, did he ask you to put on a gown?

A. Yes—he asked me to put another gown on—no.

The INTERPRETER. She just——

A. He just had me lift my blouse—open my blouse. I had pants on at the time.

The individual—who also prescribed medication for the recipient—was positively identified by the recipient as the group's lay administrator.

The Commission also discovered it a prevalent practice for Medicaid recipients to be required to sign claim forms in blank and prior to having any service rendered. This practice allows physicians to bill the program for other than services actually rendered. United States Senate Select Committee on Aging personnel who assisted the New Jersey State Commission of Investigation were required to sign forms in blank virtually at every facility visited. A comparison of claims submitted by the facilities for services allegedly rendered with detailed investigative notes itemizing services actually rendered showed gross discrepancies in many cases. Physicians billed for injections that were not given, for blood which was not drawn and for urinalysis and tine tests which were not performed.

The Commission is also concerned with the amount of time spent with Medicaid patients by physicians. In several facilities visited, undercover investigators from the United States Senate Special Committee on Aging reported that physicians would spend only minutes with them and give the most cursory examination for which Medicaid was billed $30.00. Such minimal procedures again do not appear consistent with quality medical care.

Many of the abuses outlined above—extensive use of paramedical and even lay personnel or duties which are reimbursable only to physicians, double billing, ping-ponging and family ganging—can be and are being detected by the Division of Medical Assistance and Health Services through the use of sophisticated computer screens and time studies. We commend the Division and specifically the Bureau of Medical Care Surveillance for the effectiveness of current methodology. Existing computer program comparison procedures, however, do not uncover abusive practices in each and every case, but only when certain factors are present. To further protect the intergity of the program, we recommend that the Division obtain and regularly employ the services of undercover agents who would pose as recipients seeking medical care. The Commission found that the use of such agents provided a quick, reliable and efficient method of uncovering practices inconsistent with the aims of the Medicaid program. Evidence gathered by such investigators, who we envision would be assigned to the Bureau of Medical Care Surveillance, could and should be aggressively used by the Division in suspension hearings or passed along for the review of appropriate law enforcement agencies.

We additionally recommend that facilities performing substantial amounts of Medicaid work be required to disclose to the Division the names and positions of employees. This information which, of course, should be updated periodically, will prove helpful in detecting use of para-professionals in place of physicians. We would also suggest that the Division consider legitimatizing the use of *qualified* medical para-professionals in certain instances. Services rendered by such individuals, however, should be paid at a rate lower than that now designated for physicians.

We again recommend that the Division consider the possibility of contracting with an insurance clearing house. Our own experence indicates this to be an effective step in obtaining reliable information on the presence of sources of medical payments other than the Medicaid program.

Lastly, we urge that steps be taken to insure that recipients be made aware of services billed to Medicaid on their behalf and be given an opportunity to challenge the accuracy of physician requests for reimbursement. At very least, a procedure should be instituted and strictly followed requiring recipients to

sign only completed, itemized claim forms. We further recommend that recipients be advised of services billed on their behalf, either by a Division listing of billings periodically through the year, or simply by adding a copy claim form to be given to the recipient by the physician at the time of service as a "receipt". We anticipate that costs incurred as a result of the adoption of either of these proposals would be offset by savings realized from more truthful billings. Either procedure would build a sorely needed "check and balance" into the existing system.

Unholy Alliances Between Mills and Pharmacies

During the course of the investigation, the Commission discovered a number of questionable relationships between pharmacies and mills. At one location an owner of the pharmacy and a lay "entrepreneur' 'also "owned a substantial interest in a medical center located less than a block away. The pharmacist paid the salaries of physicians at the Center and subsequently played a role in determining the "rent" physicians would pay for use of the facility. According to the pharmacist, Center patients initially numbered more than 50 a day and rose to the point where they comprised about a third of his business. We believe this estimate to be conservative.

Q. Do these prescriptions from the * * * Medical Center constitute any significant part of your business?

A. Enough to make me notice. I didn't want to lose it due to the fact when I took over my store we were only doing about fifty a day, and when the physicians were there at the medical center I had seen, you know, quite a few.

Q. Give us a ball park figure.

A. I would say about a third of my business.

Q. About a third?

A. My prescription business is from the medical center.

Q. Was that in May of 1973 or are we talking about today?

A. No. It's the same as it was.

Q. All the way through?

A. Right.

According to the pharmacist, Center patients patronized his store because of convenience. He claimed that the next closest pharmacy was four blocks away. In order to determine whether factors other than convenience were involved, personnel from the State Commission of Investigation and the United States Senate Select Committee on Aging recenly visited the subject medical center. Following an examination, a physician at the Center contacted the pharmacy by an automatic-dial phone and ordered several prescriptions for a Committee undercover investigator. The Center receptionist then directed the investigator to the pharmacy to pick up her medication.

In another area, a pharmacy and a medical center located directly across the street were sold as a "package" to a pharmacist and a lay person. Initially, physicians at this Center were paid a salary and subsequently, arrangements changed to a percentage "rental". The County Medical Society recently objected to the pharmacist and his lay partner acting as owners of the Center. Accordingly, arrangements were made to the end that the Center was "sold" to a physician. The physician now pays rent to a realty company whose principals are the former owners, a fee for the former owners to open and close the facility daily, and a fee to the "former" owner's brother who acts as facility bookkeeper. Investigators from the State Commission of Investigation and the United States Senate Select Committee on Aging who visited this facility were directed to the "former" owner's nearby pharmacy for prescriptions.

A comparison of the location of the medical center and that of the pharmacy rendering service to significant numbers of the center's patients may itself suggest impropriety. Surveillance personnel should closely scrutinize situations where pharmacies distant from centers provide service to large numbers of center patients. The Commission was surprised to find one situation where the majority of one medical facility's patients were having their prescriptions filled by a pharmacy located some five to eight miles away, notwithstanding the fact that at least two drugstores were located within blocks of the office. Prescriptions from the one facility alone accounted for 55% of the drugstore's total business and 80% of its Medicaid volume.

Investigation disclosed that the pharmacy was once a tenant of the physician. When the physician relocated to another town, direct telephone lines were estab-

lished to the subject pharmacy. The physician, as well as his registered nurse and lay office help, would phone in prescriptions to the pharmacy and the pharmacist would then type a script with the relevant information for his files. Evidence indicates that the pharmacist would be supplied with blank prescriptions pre-signed in the physician's name by his registered nurse. These blanks were apparently used in violation of Federal Law to record transactions involving controlled substances.

The medical facility involved maintained a cardboard box into which was placed drug samples left by pharmaceutical salesmen and medications returned to the physician by patients. According to several present and past employees, the pharmacy's delivery man would regularly pick these up. The facility's registered nurse described the items placed in the box as follows:

Q. All right. Now, did Mr. * * * ever take things away from Doctor * * * office?

A. Yes.

Q. What type of items would he take away?

A. Samples.

Q. What type of samples? You mean pharmaceutical samples that salesmen might drop off?

A. Yes.

Q. Any other type of material?

A. Sometimes he would pick up my laundry for me.

Q. Well, relating to medicine, would patients ever bring in syrups or pills into Dr. * * * office?

A. Yes.

Q. Well, would these ever go to Mr. * * *, these syrups or pills the patients would bring in?

A. Yes.

Another employee agreed that the box contained mainly sample pills and syrups.

Q. * * *, do you know what an injectable is, something that you inject into a patient rather than give the patient orally?

A. An injectable?

Q. Yes, an injectable is a drug that you might inject into a patient.

A. Yes.

Q. As opposed to something you might take like a pill or some syrup.

A. Yes.

Q. All right. What type of items would go into the box? What type of samples, pills or syrups or injectables?

A. Mainly pills and syrups.

The pharmacy's deliveryman recalled picking up only outdated vaccine and specifically denied ever taking pills and syrups. He recalled picking up samples only between one and three times a year. While the drugstore's employees maintained that he personally placed the medication in a trash receptacle, a real possibility exists that these items were redispensed. In addition to this possibility, the Commission has received material from the State Division of Consumer Affairs indicating that the pharmacy had been billing the Medicaid program for expensive brand name drugs while actually dispensing cheaper "look-alike" generic drugs.

Another abuse involved the short-circuiting of normal checks and balances between the pharmacy and recipients. The pharmacy's deliveryman would take the prescriptions to the facilitiy's patients. The Medicaid claim forms acknowledging receipt of and requesting payment for the medication were not signed by the recipients. They were pre-signed in the patient's name by another pharmacy employee. With such a procedure, there is no need for the recipient to ever see the claim form and no way for the recipient to compare drugs billed on his behalf with drugs actually received.

All of the facilities and pharmacies mentioned above were involved with others in an ingenious scheme designed to maximize personal profits. A lay entrepeneur who owned substantial interests in several medical centers banded togther with a relatively small group of physicians, pharmacists and clinical laboratory operators to form a company which would arrange for laboratory tests to be performed and repackage and resell relatively inexpensive generic drugs under its own brand name. Stockholders included the physicians who would write prescriptions for their corporation's products and lay medical facility owners. With each prescription and sale, stockholder equity in the corporation increased. Questions of

product quality aside, such a situation raises grave questions of conflict of interest and temptation to overutilize scant Medicaid program funds.

The Commission's investigation also surfaced what appears to be a new trend in the medical center-pharmacy alliance. More and more centers are opening with on-site pharmacies whose hours of operation exactly coincide with those of the facility. These pharmacies often "rent" small amounts of floor space at high rates and share waiting room and entrance space with physicians. Because these pharmacies cater almost exclusively to center patients, they are able to concentrate upon maintaining an inventory of only those items which center physicians prescribe. Thus, they may qualify for volume discounts or institutional rates on drugs purchased and at the same time save monies by not stocking drugs facility physicians do not commonly prescribed.

Problems of steering are exacerbated in physician groups having an on-premises pharmacy. At one facility the in-house pharmacy "rented" some 225 sq. ft. of space for in excess of $1050 per month. Entrance to the pharmacy was via the facility's door and waiting room. A plexiglas partition separated the two areas and prevented the patient from physically entering the pharmacy. Employees of the facility testified that it was the practice of the lay administrator to approach patients following an examination and say in English or in Spanish, "You can obtain the prescription at the pharmacy and you can wait in the waiting room," or "Honey, could you please take your prescription to the pharmacy and then have a seat outside." Another facility employee told of instructions to direct patients to the pharmacy which were given by the lay administrator.

Q. Would Mr. * * * instruct any of the girls or any of the doctors to send the patients in to the pharmacy?

A. Especially he told me himself.

Q. Mr. * * * told you to send patients to the pharmacy?

A. Right.

Q. What did he tell you?

A. When the pharmacy was open, he go straight to the lab and he told me that they should tell the patient to go to the pharmacy to pick up the prescription.

Q. And along with his instructions, did you tell the patients to go to the pharmacy?

A. It was in front of the patient and most of the patients understands a little bit in English.

Q. So you didn't have to tell them, they heard?

A. Right.

The same employee, who was neither a State licensed registered nurse (RN) or practical nurse (LPN)—described another ploy used upon patients to insure that prescriptions would be filled at the in-house pharmacy:

Q. Did you ever hear any of the other doctors who worked at the * * * Health Group telling patients to go into the pharmacy with their prescriptions?

A. No, only if the patient had to have penicillin injection I am. So then I have to tell the patient to go to the pharmacy and get it and bring it back to the lab. Then I give it to the patient.

Mr. Dickson. Off the record.

(Whereupon, there is a discussion off the record.)

A. (Continuing) The patient handed the needle, right.

Q. The patient handles the needle, yes.

A. And back again to the lab.

Q. Where you are?

A. I am right in my office. I call my office, anyway. I give the needles to the babies or the patients. Is the patient from Dr. * * * [the internist], sometime I give the needle for them, right, or the babies.

Q. But you have to tell the patient first you have to go to the pharmacy?

A. Yes.

Q. To get the penicillin?

A. Yes, they have to go there and sign, and the girl in the pharmacy give it to the patient. The patient come inside again and I give it to the patient.

When the patient presented the prescription for the injectable at the pharmacy window, another employee would request all other prescriptions and promise that these could be ready for pick-up after the injection was given.

The faciilty also maintained a double standard as to whether a charge would be made for injectable drugs. Private patients would not be charged for injecta-

bles while the taxpayers picked up the bill for injectables given to Medicaid recipients. An employee described the practice as follows:

Q. Now, Mrs. * * *, suppose a Medicaid patient comes in and he needs an injection of penicillin. What would happen?

A. Then the doctor give the prescription and the patient go to the pharmacy. We tell the patient, "Get in the pharmacy, get the needle," you know, because for the patient it's very easy to tell that way, and come back to the lab and I give it, the needle, to the patient.

Q. And at the pharmacy would the patient sign a Medicaid form for the penicillin?

A. Yes, they have to sign.

Q. So Medicaid would be billed for the penicillin injection, right?

A. Right.

Q. Now, suppose a private patient came, somebody who didn't have Medicaid or Medicare but was going to pay cash, and suppose the private patient needed an injection of penicillin. What would happen?

A. Well, we have a salesman supply some samples, right, and we got some sample, you know, for like we have 600 dozen units of penicillin and we keep it for special patient you know, private patient, and we supply, you know. Like a doctor do a little favor, save a little money.

Q. No charge?

A. No charge.

Q. So the Medicaid patients would have to pay for the penicillin and the other injectables, right?

A. If the doctor order, yes, yes.

Q. Yes.

A. Like Detanusdozide, D-e-t-a-n-u-s-d-o-z-i-d-e.

Q. My point is, if it's a Medicaid patient, Medicaid gets billed for the injectable; but if it's a private patient, then the patient doesn't get billed for the injectable, it comes with the visit, right?

A. Right, right, yes.

A physician-partner of the facility was questioned concerning allegations of abuse involving pharmacy and center staff. The testimony was as follows:

EXAMINATION BY MR. DICKSON

Q. Doctor, we spoke about the pharmacy being located on the premises at one point in our discussions today. Are you aware of any circumstances where anyone in the * * * Health Group would direct patients of the * * * Health Group to the pharmacy in order to have prescriptions filled?

A. I plead the Fifth and Fourteenth Amendments.

Q. Have you ever had occasion to hear Mr. * * * [lay administrator] speak to * * * Health Group's—I'm sorry—* * * Health Group patients in Spanish and direct them to the * * * Medical Pharmacy?

A. I plead the Fifth and Fourteenth.

Q. Would you sometimes write prescriptions for injectables?

A. Yes, I would.

Q. What would you do with prescriptions for injectables?

A. The same thing that I gave—that I did with the prescriptions for oral medication; gave it to my nurse.

Q. Would your nurse indicate to the patient that an injectable should be obtained from the * * * Medical Pharmacy and brought back to you so that an injection could be administered?

A. I plead the Fifth and Fourteenth Amendments.

Q. Doctor, did Mr. * * * or anyone else at the * * * Medical Group or Medical Pharmacy suggest to you that Medicaid patients should be regularly given vitamins?

I'm getting a mixed response.

ATTORNEY: You're not getting any response yet.

A. I plead the Fifth and Fourteenth Amendments.

Q. Did Mr. * * * or anyone else at the * * * Medical Group or Medical Pharmacy give you suggestions or advise as to prescribing vaporizers for patients of the * * * Health Group?

A. I plead the Fifth and Fourteenth Amendments.

The Commission has received material from the State Division of Consumer Affairs indicating that the subject pharmacy short-weighted or short-counted

medications going to Medicaid recipients. Information from the Division of Medical Assistance and Health Services suggests over-prescribing of vitamins, preparations and vaporizers.

In another pharmacy, which had a direct telephone link to a doctor's office, evidence of the following additional abusive practices came to light: Medicaid recipients were required to sign forms in blank and prior to receiving medication; billing Medicaid for drugs not dispensed; billing Medicaid for drugs covered by the program and dispensing a drug not so covered; tracing recipients' signatures from old claim forms onto blank forms and billing for drugs allegedly supplied to recipients who were deceased.

A major step in reducing program costs was taken during the pendency of the Commission's probe by the Division of Medical Assistance and Health Services. Under present regulations, generic rather than brand drugs should be prescribed and dispensed whenever possible. Additional steps can be taken to further reduce abuse and unnecessary expenditure of limited program monies. The Division currently has the computer capability to develop a prescribed profile on Medicaid program physicians. This program would analyze prescribing patterns of physicians and display questionable or abusive practices. Unfortunately, the profile is not effectively used because program providers choose not to supply necessary information on claim forms. We recommend that the Division assume a tough stance on this issue and reject for payment any claims not containing relevant information.

To facilitate the gathering of information relevant to program integrity, we suggest that a standard Medicaid multi-copy prescription/claim form be developed. The name of the prescribing physician could be pre-stamped on the form. The physician should list the medication desired and draw a line immediately under the last item prescribed and personally sign the form. Space can also be provided for the physician to list a substantiating diagnosis. A copy can be kept for the physician's record and the balance forwarded to the pharmacy via the patient for use as a description of drugs to be dispensed and the pharmacist's billing invoice.

Existing program regulations prohibiting the referral of patients to a particular pharmacy by physicians should be broadened to encompass all facility employees and stringently enforced. It should be made clear to all that the physician may not require nor may he recommend that a prescription be filled by a particular pharmacy; nor may his receptionist or any employee do so. Patients who ask must be reminded of their free choice of pharmacy. Any liaison—including direct telephonic connection and common entranceway—between physician and pharmacist should create a presumption of impropriety. Landlord-tenant and other relationships between physicians and pharmacists should be subjected to special scrutiny as to pharmaceutical utilization.

Landlord tenant relationships present perhaps the greatest temptation to overutilize pharmacy services. Even without direct steering by facility staff, patients are usually required to pass the pharmacy entrance to pick up coats or children before arriving at the public street. The in-house pharmacy truly has a "captive" audience. For this reason, the common entranceway should be prohibited. Moreover, when a physician or a landlord owns a pharmacy or has a pharmacy for a tenant, he is induced to take whatever steps are necessary to see that the pharmacy succeeds. In-house pharmacies also present opportunity for profit based upon the precise nature of inventory kept and the ability to obtain volume discounts on drugs. We recommend that the Division take these savings into consideration along with the fact that in-house pharmacies primarily—if not exclusively—service patients of the facility and reimburse these pharmacies at a lower institutional pharmacy Medicaid rate. We further suggest that the professional boards in their licensing schemes take into account the great potential for overreaching present when pharmacies enter into financial relationships with physicians located on the same premises.

Recommendations

The Commission has already recommended substantial changes in program legislation and administrative practices and procedures in previous reports on nursing homes, independent clinical laboratories and hospitals participating in the New Jersey Medicaid Program. Many of these previous recommendations—such as those calling for criminal sanctions against kick backs, establishment of a scheme of financial penalties for incidents of fraudulent conduct, subpoena

power and accountants for the Division of Medical Assistance and Health Services, and increased monitoring of fiscal agent actions—have effect in several program component areas. We take this opportunity to supplement the record with recommendations pertinent to the administration of the physician groups aspect of the program.

1. Shared Health Care Facilities receiving substantial amounts of Medicaid funds should be identified and annually approved for program participation by the Division of Medical Assistance and Health Services. Practitioners rendering service and the facility at which service is rendered should clearly be identified. We have reviewed proposals drafted by the Division of Medical Assistance and Health Services to achieve these goals and concur with their substance (see appendix for copy). We pause, however, to add our own suggestions.

D. PROHIBITED PRACTICES—ADMINISTRATIVE REQUIREMENTS

1. Percentage letting prohibited—The rental fee for letting of space to providers in a shared health care facility or the remuneration of providers for services in such facility shall not be calculated wholly or partially, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered in the premises in which the shared health care facility is located. A copy of each lease or details of any agreement between the facility and any provider and any renewal thereof shall be filed with the Division.

5. The Commission understands that the separate entrance requirement imposed by this section is applicable to in-house pharmacies.

6. Claims—All provider claims submitted for services rendered at a shared health care facility shall (a) contain the registration code of the facility at which the service was performed and (b) be personally signed by the practitioner who rendered service (c) contain the code number of the physician who rendered the service, (d) be personally signed by the patient who received the goods or service.

8. Order for ancillary clinical services—all orders issued by providers for ancillary clinical services, including, but not limited to, x-rays, electroencephalograms, as well as orders for medical supplies and equipment, shall contain the registration code of the facility at which the order was written and the code number of the provider requesting the service or goods.

A line shall be drawn under the last good or service requested and the diagnosis justifying the request and requesting providers personal signature shall be placed below that line.

10. Direct telephonic links between providers is prohibied.

11. Providers shall not order ancillary clinical services from providers in which they hold a financial interest.

12. Providers shall not submit claims to medicaid who also claim reimbursement for identical services from another third party payor. All information requested concerning possible third party liability shall be listed on claim forms.

2. We strongly recommend that the Division obtain and regularly employ the services of undercover agents who would pose as recipients seeking medical care. Evidence of improprieties gathered by these agents could and should be aggressively used by the division in suspension hearings or passd along for the review of appropriate law enforcement agencies.

3. Medicaid recipients should be made aware of services billed to the program on their behalf and be given an opportunity to challenge the accuracy of physicians requests for reimbursement.

Lastly, and perhaps most importantly, we recommend that there be constant and close coordination between Division Surveillance personnel and those responsible for the review and promulgation of administrative regulations applicable to program providers. Many of the abuses identified by the S.C.I. were previously found by surveillance personnel, and passed along for further action. Unfortunately, in many instances warnings of potential wide-spread abuse noticed by the Bureau of Surveillance and passed along to others seem to have fallen through the cracks of bureaucracy. The Commission notes that conditions have improved and many aggressive, explicit regulations have been promulgated during the course of our own investigation by new Division leadership. We fully expect that such efforts will continue.

Copies of the investigative record compiled by the Commission in this probe will be forwarded to the State Attorney General, the United States Attorney for the State of New Jersey, the State Board of Medical Examiners, the State Board of Pharmacy, the Division of Medical Examiners, the State Board of Pharmacy, the Division of Medical Assistance and Health Services and the State Legislature for further review and consideration.

Appendix to Report

Requirements Applicable to Shared Health Care Facilities

A. DEFINITIONS (WHEN USED IN THIS ITEM)

1. Department shall mean the Department of Institutions and Agencies.
2. Division shall mean the Division of Medical Assistance and Health Services.
3. Program shall mean the New Jersey Health Services Program.
4. Shared Health Care Facility shall mean two or more providers delivering health care, either independently or in association with each other, within a single structure and (a) two or more of whom share any of the following: common waiting areas; examining rooms; treatment rooms; equipment; supporting staff; any shared space; or common records, and (b) one or more of whom receives payment on a fee-for-service basis.
5. Provider shall mean any person, firm, corporation or other entity providing services under the Program.
6. Purveyor shall mean any person, firm, corporation or other entity who, whether or not located in a building which houses a shared health care facility, directly or indirectly, engages in the business of supplying to ultimate users any medical supplies, equipment and/or services for which reimbursement under the Program is received, including, but not limited to, clinical laboratory services or supplies; x-ray laboratory services or supplies; inhalation therapy services or equipment; ambulance services; sick room supplies; physical therapy services or equipment; orthopedic or surgical appliances or supplies; drugs, medication or medical supplies; eye glasses, lenses or other optical supplies or equipment; hearing aids or devices; and any other goods, services, supplies, equipment or procedures prescribed, ordered, recommended or suggested for medical diagnosis, care or treatment.
7. Patient shall mean anyone eligible to receive benefits from the Program.

B. APPLICATION OF ITEM

1. This Item shall apply to shared health care facilities as defined herein and to the providers located in a specific health care facility.
2. This Item shall apply to purveyors, whether or not located in a building which houses a shared health care facility.
3. Nothing in this Item shall apply to an association of health care practitioners delivering health services on other than a fee-for-service basis.

C. REGISTRATION OF SHARED HEALTH CARE FACILITIES

1. No shared health care facility shall be operated under the Program unless the owner or, if the structure in which the shared health care facility is located has been leased, the person who leases space in the shared health care facility, has registered such facility with the Division. Registration shall be made on forms furnished by the Division and shall contain the information required therein, including, but not limited to—

(*a*) The name and residence address of every person, partnership or corporation having any financial interest in the ownership (including leasehold ownership) of the structure and of the shared health care facility;

(*b*) The name and residence address of every person, partnership or corporation holding any mortgage, lien, leasehold or any other security interest in any equipment located in and used in connection with a shared health care facility and a brief description of such lien or security interest;

(*c*) The name, residence address and professional license number of every practitioner working in the shared health care facility. This information shall be maintained on a current basis. Division shall be notified of any

change in the status of practitioners within the shared health care facility; and

(*d*) The name, residence address and professional qualifications of the individual designated to assume responsibility for the central coordination and management of the shared health care facility's activities.

2. The registrants shall re-register on the June 1 next following the initial registration and annually thereafter on June 1.

3. The Division shall be notified by the shared health care facility of any change in—

(*a*) The persons, partnerships or corporations having any financial interest in the ownership (including leasehold ownership) of the share health care facility; or

(*b*) The persons, partnerships or corporations holding any mortgage, lien, leasehold or any other security interests in any equipment located in and used in connection with a shared health care facility. A statement of the monetary and repayment provisions of that lien or security interest shall accompany such notification.

4. The Division shall be notified within fifteen days of the termination of the services of the individual designated to assume responsibility for coordination and management of the shared health care facility's activities. The division shall also be notified within fifteen days of the name, residence address and professional qualifications of any new individual appointed to assume such central administrative responsibility.

5. The Division shall be notified within fifteen days of any termination of the services of any practitioner in the shared health care facility. Such notification shall include the name, residence address and license number of each person appointed in place of such individual.

D. PROHIBITED PRACTICES; ADMINISTRATIVE REQUIREMENTS

1. Percentage letting prohibited: The rental fee for letting of space to providers in a shared health care facility shall not be calculated wholly or partially, directly or indirectly, as a percentage of earnings or billings of the provider for services rendered on the premises in which the shared health care facility is located. A copy of each lease and any renewal thereof shall be filed with the Division.

2. Referral fees prohibited: No purveyor or provider, whether or not located in a building which houses a shared health care facility, shall directly or indirectly offer, pay or give, or permit or cause to be offered, paid or given to any provider or purveyor, and no provider or purveyor shall directly or indirectly solicit, request, receive or accept from any purveyor or provider any sum of money, credit or other valuable consideration for—

(*a*) Recommending or procuring goods, services or equipment of such purveyor or provider for any other person, or

(*b*) Directing patronage or clientele to such purveyor or provider, or

(*c*) Influencing any person to refrain from using or utilizing goods, services or equipment of any purveyor or provider.

3. Patient referrals:

(*a*) No provider in a shared health care facility or person employed in such facility shall refer a patient to another provided located in such facility unless the records of the referring provider pertaining to such patient clearly sets forth the justification for such referral;

(*b*) Every provider practicing in a shared health care facility who treats a patient referred to him by another provider practicing in the same facility shall communicate in writing to the referring provider the diagnostic evaluation and the therapy rendered. The referring provider shall incorporate such information into the patient's permanent record; and

(*c*) The invoice submitted to the Program by the provider to whom such patient has been referred shall (1) contain the full name and provider number of the referring provider and (2) identify the medical problem which necessitated the referral.

4. Pharmacy notice: Any pharmacy maintaining a business in the same building in which a shared health care facility is located shall prominently post a notice informing patients that all pharmaceuticals prescribed in the Program

may be obtained at any pharmacy of the patient's choice enrolled in the Program in the city.

5. No entrance on the premises by purveyors: No purveyor who maintains a business in the building in which a shared health care facility is located shall maintain a door or window opening into the offices or waiting room of the shared health care facility, except where the profession of the provider permits the provider to function simultaneously as a purveyor.

6. Claims: All provider claims submitted for services rendered at a shared health care facility shall (a) contain the registration code of the facility at which the service was performed and (b) be signed by the practitioner who rendered service.

7. Billing: In a shared health care facility, procedure code 9000 (Initial Office Visit) or 9580 (EPSDT), or 9001 (Comprehensive Office Visit) may be billed only once. All referrals within the shared health care facility will be billed as 0001 (Routine Office Visit), 0005 (Brief Office Visit), or 9007 (Prolonged Office Visit). Use of 9029 and 9030 Consultation codes are prohibited. If an ophthalmologist is a member of the shared health care facility and a comprehensive eye examination, including refraction, is performed, then procedure code 5400 may be used.

8. Orders for ancillary clinical services: All orders issued by providers for ancillary clinical services, including, but not limited to, x-rays, electrocardiograms, clinical laboratory services, electroencephalograms, as well as orders for medical supplies and equipment, shall contain the registration code of the facility at which the order was written.

9. Fee splitting prohibited: It shall be unlawful for any provider to pay a bonus, commission or fee to any other provider based on business supplied or referred, except where the paying of a fee is compensation for services rendered to the patient.

E. QUALITY OF CARE REQUIREMENTS

1. To ensure quality, continuity and proper coordination of medical care each shared health care facility shall—

(*a*) Designate an individual, who, on a full-time basis, shall coordinate and manage the facility's activities. The person so designated shall be responsible for compliance with the provisions of this Item.

(*b*) Devise an appropriate means of insuring that (1) patients will be scheduled to return for appropriate follow-up care and (2) will be treated by a practitioner familiar with the patient's medical history.

(*c*) Post conspicuously the names and scheduled office hours of all practitioners practicing in the facility.

(*d*) Maintain proper records. Such records shall contain at least the folllowing information:

(1) The full name, address and Medicaid number of the patient.

(2) The dates of all visits to all providers in the shared health care facility.

(3) The chief complaint for each visit to each provider in the shared health care facility.

(4) Pertinent history and all physical examinations rendered by each provider in the shared health care facility.

(5) Diagnostic impressions for each visit to any provider in the shared health care facility.

(6) All medications prescribed at each visit to any provider in the shared health care facility who is qualified to issue prescriptions.

(7) The precise dosage and prescription regimens for each medication prescribed by a provider in the shared health care facility.

(8) All x-ray, laboratory work and electrocardiograms ordered at each visit by any qualified provider in the shared health care facility.

(9) The results of all x-ray, laboratory work and electrocardiogram ordered as in "8" above.

(10) All referrals by providers in the shared health care facility to other medical practitioners and the reason for such referrals, and date of referral.

(11) A statement as to whether or not the patient is expected to return for further treatment.

(*e*) Inspection of records—The Division shall have the right to inspect the business records, patient records, leases and other contracts executed by any pro-

vider in a shared health care facility. Such inspections may be by site visits to the shared health care facility.

(*f*) Names of providers to be filed with Division—Every shared health care facility shall file with the Division the name of each provider or purveyor currently rendering services in such facility. If any provider vacates a facility or a new provider is added therein, such change shall be reported to the Division by registered mail within fifteen days of such change.

EXHIBIT B

It is recommended that a committee of staff and contractor personnel be formed to analyze and prepare a report recommending changes in existing computer capability related to provider identification and service tracking. Specifically, this committee suggests reducing the provider number from a 9 digit code to a 5 digit code, thereby allowing utilization of the remaining 4 digits to identify the provider group and the individual practitioner who rendered the service. It is believed that other applications of the 5–4 digit system could be developed. Although this recommendation is extremely general, it should serve as the starting point for the committee to commence its work.

Appendix 2

CORRESPONDENCE BETWEEN SENATOR FRANK E. MOSS AND DEANS OF SCHOOLS OF MEDICINE

DEAR DEAN: You may have read about the recent investigation and disclosures concerning fraud and abuse in the Medicaid program revealed by my Subcommittee on Long-Term Care. These news stories also conveyed much of my worries about the quality of medical care being rendered to the poor, aged, blind and disabled.

I am writing to enlist your support for increased involvement of schools of medicine with public health clinics, hospital outpatient clinics and shared health facilities which are the primary sources of medical care to residents of America's inner cities. Many medical schools already have a significant number of initiatives in this area, but I believe there is a need to intensify our efforts.

I would appreciate any suggestions you might have on the question of greater involvement of medical schools in providing treatment for indigents, the aged, blind and disabled. Moreover, I would be grateful for any suggestions about improving the fiscal integrity of government health programs.

In closing, I want to underscore the fact that my Subcommittee has repeatedly stated that only a tiny minority (4 percent) of physicians cheat government programs; nevertheless, the dollars involved are substantial. The Medicaid program increasingly has been turned over to foreign medical practitioners who often lack requisite skills to compete with American trained physicians.

Again, I would be grateful for any suggestions you might have for dealing with these problems.

FRANK E. MOSS,
Chairman, Subcommittee on Long-Term Care.

ITEM 1. LETTER FROM DR. JOHN I. SANDSON, DEAN, BOSTON UNIVERSITY MEDICAL CENTER, BOSTON, MASS.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 21, 1976

DEAR SENATOR MOSS: Thank you for your letter of September 7. It is important to get more medical school involvement in ambulatory care settings. Some medical schools are interested in doing this. One major difficulty in moving forward has been the inability to pay for the necessary teaching costs in ambulatory settings. This is a major problem that has to be overcome if substantial progress is going to be made.

I would be most pleased to meet with you to discuss this further at your convenience.

Sincerely,

JOHN I. SANDSON, M.D.

ITEM 2. LETTER FROM DR. D. KAY CLAWSON, DEAN, COLLEGE OF MEDICINE, UNVERSITY OF KENTUCKY, LEXINGTON, KY.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 21, 1976

DEAR SENATOR MOSS: Thank you for your letter of September 7, asking for suggestions that might improve the opportunities for treatment of the indigents, aged, blind and disabled. I, too, share your concerns yet take this opportunity to call to your attention the serious financial plight facing many of our medical schools. I am sure you are barraged with data from the AAMC so I would like to only state the position faced by the University of Kentucky.

We are the only city, county, state institution serving Eastern Kentucky with 1.5 million people. Our 463 bed University Hospital provides tertiary care for people of all levels. It is the only place that can do renal dialysis and transplants, open heart surgery, specialized burn care and advanced radiation therapy for the people of this region. Because there is no other resource, we end up providing an inordinate volume of unreimbursed care (22.2 percent of total services in 1975–76). We do this trying to deal with inflation and respond to advances in medical technology and support this effort with state funds for hospital operations which have not increased since 1968. We are the primary center for the care of Medicaid patients. Medicaid funds support 30 percent of our patients.

From the standpoint of our clinical faculty, we must generate 79 percent of our faculty income from outside sources including grants and fee for service practice. Given the large indigent and non-pay population which we service in an undistinguishing manner from full-pay patients, we do not have an adequate budget to hire the clinical teaching faculty necessary to care for the patients and maintain our teaching and research program at the level expected for an academic institution of this quality.

The State has been unable to pay fee for service under the Medicaid program higher than 62 percent of the 75th percentile of usual and customary fees as charged in 1973. This means that the fees collected are frequently so low that physicians in and around the state will not take care of Medicaid patients, therefore, these patients can only come to our institution. Many of our patients are classified as medically indigent and receive financial allowances even though they do not qualify for the Medicaid program. The physicians are giving services to medically indigents and Medicaid allowances of about $3.0 million. We hold regional clinics in Pediatrics, Neurology and Community Medicine in an effort to provide better care for our citizens.

Our fee for service income must be used to subsidize the teaching program. We have active teaching areas in a variety of courses and a major component in community medicine teaching the problems of the indigents, of the nursing home patient, and the disabled. In addition, we are now requesting some governmental support to develop an Aging Institute here that will combine our resources of the Sanders-Brown Center for Biological Research in Aging with outreach programs using the resources of several of the Colleges and Departments of the University plus the community college system.

In summary, we believe that we are doing an outstanding job in attempting to answer the problems you stated in your letter but are so completely strapped financially that we are having a struggle to meet the needs of all of the constituencies. The falling off of our capitation money from $855,000 in 1975 to $398,000 this year only compounds the problem. It is unfortunate that at a time when we are desirous of doing so much, inflation at the rate of 10 or 12 percent is moving faster than our state support and other resources.

I do not have any magical solutions but know from my experiences as a faculty person at the University of Washington, that there was a tremendous difference in the level of care being rendered to the underserved populations when the State of Washington changed from a concept of an indigent or charity hospital and gave all indigent or medically indigent patients an opportunity to select the physician and the hospital of their choice through a Medicaid program that paid usual and customary fees. Most physicians and other faculty members at the University of Kentucky and I am sure other medical schools are extremely concerned about this problem and would like to join with you in efforts to alleviate the situation. However, we are already so financially strapped trying to meet our teaching commitments while taking care of large numbers of indigent patients that it is very difficult to expand any activity.

Most sincerely,

D. Kay Clawson, M.D.

ITEM 3. LETTER FROM DR. JOHN P. UTZ, DEAN, GEORGETOWN UNIVERSITY SCHOOL OF MEDICINE, WASHINGTON, D.C.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 21, 1976

Dear Senator Moss: I am pleased to acknowledge your memorandum of September 7 and its request for suggestions on how medical schools might be more greatly involved "in providing treatment for the indigent, the aged, blind, and disabled.

Georgetown University has been for 25 years, is now, and expects to be committed in the future, to the care of just exactly the patient you cite, particularly at the District of Columbia General Hosptial. In salaries of attending physicians, house staff, and consultants we calculate the annual contribution to be approximately $1 million a year.

We also serve the Area A Psychiatric Clinic for inner-city citizens.

To the best of my knowledge, none of our faculty receive any Medicaid support for such extensive service to our central inner-city citizens.

I hope this is a help to you.

Sincerely,

JOHN P. UTZ, M.D.

ITEM 4. LETTER FROM DR. JOHN A. DIXON, VICE PRESIDENT FOR HEALTH SCIENCES, UNIVERSITY OF UTAH, SALT LAKE CITY, UTAH; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 21, 1976

DEAR SENATOR MOSS: Thank you very much for your letter of September 10 regarding increased involvement of schools of medicine with public health clinics, hospital outpatient clinics and shared health facilities which are the primary sources of medical care to residents of America's inner cities. I can assure you that the University of Utah College of Medicine is deeply involved in all of these areas and has formed significant relationships with ten of the state's community hospitals to provide resident support for manning of just such facilities.

A statistic you might be interested in is as follows: In 1974, the percentage of the population of Utah over 65 years of age was about 7.5 percent. The percentage of patients over 65 served by our University Medical Center over the past year was 17 percent and the percentage of patient days for people over 65 was 22 percent. These figures indicate that a substantial portion of the Medical Center activities are directed toward meeting the needs of the geriatric community.

The colleges in the University of Utah Health Sciences Center (Nursing, Pharmacy, Medicine and Health) are currently involved in long-range planning affecting the indigent, aging, blind and disabled population. In particular, the College of Nursing is involved in some very innovative programs in nursing homes to improve badly needed care there.

We appreciate all you have done for medical education in the west and will continue to work with you to eliminate these areas of health care deficiency.

Sincerely,

JOHN A. DIXON, M.D.

ITEM 5. LETTER FROM DR. RAYMOND D. PRUITT, DEAN, MAYO MEDICAL SCHOOL, ROCHESTER, MINN.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 22, 1976

DEAR SENATOR MOSS: We have followed with interest news reports about your recent investigations of the Medicaid program. We share your concerns about both the cost and quality of medical care, as all except a "tiny minority," to use your own words, of physicians and health care institutions do.

Mayo Medical School, which enrolled its first class in 1972, is owned and operated by Mayo Foundation, and its patient component is drawn from Mayo Clinic. This experience is supplemented by affiliations with 54 family physicians in the nearby area. In Mayo's first graduating class, 59 percent of the students elected primary care residency training.

Because the geographic settings of medical schools vary, it seems to us that each medical school must make an effort to be responsive to the particular needs of its own area. In the case of Mayo Medical School, this area is predominantly rural. We know you are aware, as are your colleagues in the Congress, that efficient and responsive delivery of health care in a rural area is also a challenge and Mayo is responding to that challenge.

The larger institution of which the medical school is a part, Mayo Clinic-Mayo Foundation, continually directs a major share of its administrative expertise to improving efficiency in health care delivery and holding down costs. Moreover, we believe that in the group practice of medicine in this institution there exists intrinsic forms of peer review which are conducive to excellence of care and which remove the incentive for unprofessional behavior, including fraudulent

charges. These desirable features are enhanced by the fact that members of our staff are salaried on an annual basis that is not profit-sharing.

We should be pleased to have you or any member of your committee visit us, with or without notice. We recognize the limitations of our experience and our expertise, but we would be pleased to share them to the extent possible.

Sincerely yours,

RAYMOND D. PRUITT, M.D.

ITEM 6. LETTER FROM DR. ALLEN W. MATHIES, JR., DEAN, UNIVERSITY OF SOUTHERN CALIFORNIA SCHOOL OF MEDICINE, LOS ANGELES, CALIF.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 24, 1976

DEAR SENATOR MOSS: I am pleased to respond to your letter of September 7th, in which you express your concern about the quality of medical care being rendered to the poor, aged, blind, and disabled. The investigations have received very extensive national coverage. Because the issue is complex, I am responding at some length.

At USC School of Medicine our prime teaching facilities are public hospitals in which we direct the professional care in partnership with the County of Los Angeles. Our medical school classes have been more than doubled over the last decade and this academic year began with 550 medical students enrolled; more than 100 are ethnic minority students. We are also responsible for the postgraduate education of approximately 1,000 interns, residents, and fellows, many of whom come to us from completely different training settings.

USC School of Medicine does not own a university-owned teaching hospital and because of our public hospital setting we have emphasized upgrading of quality medical care and sensitization of medical students to the whole human being from their entrance into medical school through our Introduction to Clinical Medicine course. We have worked with lay consumers in the community to develop responses to their concerns and have establish patient care units in the hospital which have become national models. This type of quality medical care requires adequate funding, however, many of the reimbursement standards of publicly funded programs do not provide. Let me provide some examples of our patient mix, to which medical students and house staff are exposed, and the subsequent dollar funding problems.

At the Los Angeles County-USC Medical Center, there are approximately 8,000 inpatient admissions per month of which 10% are Medicare patients. Of the 10%, over 88% are more than 65 years of age; 12% are under 65 years of age. This means that about 800 patients are elderly and our students are involved in the care of this population in their required clinical clerkships on the hospital wards. Of the remaining 90% of the inpatient population, 37% are Medi-Cal (Medicaid) patients and 42% are "self pay". To us, self pay means that some of them have some resources but if the hospital cannot recover the costs of their care, the County of Los Angeles bears the health care costs. Eight percent of the patients are covered through Crippled Children Services funding and Short-Doyle funds, and the remaining 3 percent fall in the deferred category (which include prisoners).

Now, unlike a privately owned hospital or a community hospital, public hospitals must accept every patient who presents at the hospital for care. Private or community hospitals may turn patients away if they cannot pay for their care or if their medical problem is not of interest for teaching purposes, i.e., alcoholism or drug overdose, aging, chronic illness. If, after receiving medical care, the patient cannot pay his health care costs and is not eligible for Medicare or Medi-Cal, the County of Los Angeles must pick up the costs. Lack of adequate reimbursement from the funded programs has placed a very severe strain on the ability of the County of Los Angeles to provide funds for high quality medical care and the taxpayers of the county have been very vocal this year about the high costs of medical care over and above the reimbursement schedules. Along with the county officials, we are concerned about the large number of illegal aliens in this area who fall into the "self pay" category.

In suggesting remedial measures concerning the failure to provide quality medical care, funding is, of course, one critical issue. We feel that stressing an ethical approach to health care professions in instruction of medical students is another issue which must be stressed in ever more relevant terms. "Ethics" means something to young physicians in the context of viewing the person as a

human being of worth—I feel your investigations have sharpened the importance of this issue. But it takes time for the physician to build a caring relationship with his patients and if he is overworked, overtired, and neglecting his own family until long into the night, he tends to become cynical and uncaring. And, again, time costs money.

The issue of maldistribution of physician manpower is another facet of the problem. I recommend the Report of the National Conference on Health Manpower Distribution as a document which raises the issues we must solve in this area and the problems faced by physicians who seek to practice in the disadvantaged urban and rural areas.

Licensing standards also impinge on this problem. Some states have very loose laws for licensure which favor the unscrupulous, either U.S. trained or foreign medical graduates. California laws are so strict, for example, that obtaining a license to practice without demonstration of competence is virtually impossible. It has not eliminated the incompetent entirely, but it has reduced the problem compared to some of the eastern states.

Our late Dean, Franz K. Bauer, M.D., used to say that the practice of medicine today is being asked to solve problems of society entirely unrelated to medicine's ability to solve. For instance, good nutrition is not possible for the person who does not have the money to buy food. The problems that your committee faces are formidable and I support your concern and determination to seek to develop a health care system that the nation can afford and that works. This medical school will always be willing to assist in the solution of that challenge.

Sincerely,

ALLEN W. MATHIES, Jr., M.D.

ITEM 7. LETTER FROM DR. WILLIAM R. DRUCKER, DEAN, UNIVERSITY OF VIRGINIA SCHOOL OF MEDICINE, CHARLOTTESVILLE, VA.; TO SENATOR FRANK E. MOSS, DATED OCTOBER 15, 1976

DEAR SENATOR MOSS: As you know, we in medicine share your concern regarding fraud and abuse in the Medicaid program and have suggested that those physicians participating in such activities should be prosecuted to the full extent of the law. Whether our society is more or less afflicted than any in the past is not clear, but, we do seem to have considerable problems with integrity at all levels. Our profession, like yours, is not immune to these problems.

I am pleased to note that our medical school is one of those which has always provided extensive service to the poor, aged, blind and disabled of our region. We are the major referral center for the entire western portion of this state and serve as a community hospital for a large portion of the rural population in our vicinity. Our average patient travels some 90 miles to our facility.

The most difficult question you ask is that referring to the fiscal integrity of government health programs. In the past physicians dealt directly with a patient and were paid by the patient; they were constrained to make certain that the patient understood the reason for the fee. The patient had every opportunity to complain about the fee or to make arrangements for deferred payment or, sometimes payment by barter. When third parties intervene between the patient and the physician, several things change: patients think less about the cost of services they demand, physicians consider less the effect of the charge, and the insurance company simply passes the increased cost on to the insured. Patients frequently demand extra days in the hospital or unnecessary hospitalization, because they have paid premiums to this or that insurance program for many years and want something in return. Insurance is no longer a hedge against catastrophe, but an investment to be collected at some particular point in life.

In order to correct these misuses of government and other forms of health programs a major public education effort is needed. This effort must include facts about the real cost of such programs and the patients must be made responsible for part of their own bill in order that they not make excessive demands.

Finally, I would like to make a suggestion that you interview some practicing physicians on a one-to-one basis to gather from them first-hand their programs in dealing with government programs. As Dean of the Medical School I come into contact with such programs, only indirectly, but practicing physicians have complained that the regulations and lack of balance of such programs make it almost impossible to deal with them. I have heard of physicians who see patients eligible for medicaid and never send a bill for the simple reason that it is too complex and costly to submit the bill; they would rather see the patient with-

out charge. I do not believe that you can appreciate the real feeling of physicians by dealing with agency heads, representatives of various professional groups or by asking a practicing physician to appear before your committee where he would be ill at ease. There are many excellent physicians in the Washington area in the private practice of medicine who could give you a great deal of information about these programs if you have time to sit down with them in your office.

I hope these thoughts will be of some use to you.

Kindest regards,

Sincerely,

WILLIAM R. DRUCKER, M.D.

ITEM 8. LETTER FROM DR. JOHN A. D. COOPER, PRESIDENT, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, WASHINGTON, D.C.; TO SENATOR FRANK E. MOSS, DATED OCTOBER 20, 1976.

DEAR SENATOR MOSS: I have read with a great deal of interest your letter of September 9 enlisting the support of the Association of American Medical Colleges "for increased involvement of schools of medicine with public health clinics, hospital out-patient clinics and shared health facilities which are the primary sources of medical care to residents of America's inner cities."

Over the last several years, the staff of the Association has had many discussions with various members of its constituency on the set of issues raised by your suggestion. There are essentially two important questions to be resolved. One concerns the proper role of the medical schools in community service while the other relates to the financial integrity of these institutions. Let me review briefly the range of views held by the nation's medical schools on these problem areas.

The question of the extent to which educational institutions in general and medical schools in particular should be involved in community service, e.g., the provision of health care to the indigent citizens of our inner cities, has been a subject of lively debate within this constituency for many years. The debate is premised on the fact that the primary purpose of a school of medicine is to educate physicians; no other institutional form for that purpose exists within our society. Additionally, it is recognized that the clinical training of the medical students has been characterized for the last three quarters of a century in this country by a style and tradition which couples education and service. This contrasts with other traditions in which both pre-clinical and clinical training are largely if not exclusively didactic, carried out by lecture rather than clerkship and completely decoupled from patient care. Non-educators, seeing the service component of the "joint product", frequently view medical schools as primarily medical service institutions and call upon them to expand commitments in the service area. Many of the nation's medical schools have responded to such importunings and greatly expanded the amount of community service which they render. In calendar year 1974, the Association of American Medical Colleges surveyed the then 396 medical school affiliated hospitals belonging to its Council of Teaching Hospitals; 303 reported that among the 5,977 non-federal short term hospitals they alone accounted for 21% of the total of 194.8 million out-patient visits, 16% of the total 67.1 million emergency room visits and 22.9% of the total 1.5 million home care visits. Clearly, the medical schools of the country are already deeply involved in the delivery of health care as an inseparable part of the discharge of their primary objective, the education of medical students. The extent to which this can be increased cannot be stated with precision, but I am sure that most of the medical schools would be quite willing to undertake further responsibilities for the medical care of the indigent populations of our inner cities as long as it does not interfere with their basic educational mission.

The crucial question is the extent to which service can be expanded without interfering with the process of education. No medical school is unwilling to provide community services to the degree that that particular school believes is feasible; on the other hand, there is great variability among schools in the perception of the level of community service that begins to compromise the educational process.

The other major consideration relevant to your suggestion is financial. The type of service most important to the group of Medicaid and Medicare patients central to your interests is that which is rendered on an ambulatory basis in the out-patient clinics of the teaching hospitals affiliated with the nation's medical schools. The financing of ambulatory care facilities is one of the most troublesome

problems facing the medical schools at the moment; most of them are sustaining very substantial financial losses in the operation of these facilities. A number of factors have been identified as contributing to the deficit operations. Many insurance plans provide no reimbursement for ambulatory care. While Medicare and Medicaid do, both of these federal programs reimburse on fee schedules considerably below the average and customary. Since the overwhelming number of patients who seek care in the nation's medical centers are indigent, they are, moreover, unable to pay the "deductible" and "co-insurance" components required by various plans even when they are covered by some type of insurance. Thus, income is severely reduced.

At the same time, the conduct of teaching exercises for both undergraduate and graduate medical students in connection with the ambulatory services substantially reduces the efficiency of the medical care process, for the obvious reason that it takes additional time per patient if students are going to participate in their workup. The inefficiencies thus induced substantially raise the cost of handling the patient in a situation in which reimbursement is inadequate for even efficient operations. Finally, Medicare denies reimbursement under Part A for the costs of educating interns and residents in ambulatory facilities and recovery of these costs under other programs is equivalently unsatisfactory.

Thus, the schools will have to ponder deeply the question of whether or not they can afford this type of community service before taking on further responsibilities for the care of ambulatory patients. In spite of these financial problems, some institutions have in the past few years made significant progress in reorganizing their ambulatory services so as to provide effective and reasonably efficient one class ambulatory comprehensive care to the surrounding communities. Most have required outside funding, over and above the reimbursable health care dollar, in order to make this conversion. Many others are prepared to accomplish the necessary organizational and structural rebuilding of the ambulatory services if they can be assured of some stable reimbursement procedures.

Cognizant of these developments, the Association has during the past year sponsored a program of workshops addressing the issue of ambulatory care restructuring. Material relating to this program is enclosed for your review. The interest among our constituent institutions is high. We have reason to believe that we could easily attract thirty other large urban-based university affiliated ambulatory centers to similar workshops if we could secure the necessary funding to carry the program into 1977.

We believe the several concerns which these workshops address are in complete accord with those raised during the recent committee hearings on the quality of medical care for the urban poor. We are convinced that a large number of the nation's medical schools and affiliated teaching hospitals stand ready to assume responsibility for improved care for inner city residents, addressing many of the problems enumerated in your committee reports. The major problem is that of identifying a means of long-term, stable financial reimbursement for services provided, and a means for stable support of the associated educational programs.

I and members of the Association of American Medical Colleges staff would be pleased to meet with you and other members of the Committee, and with Committee staff to discuss these problems of mutual interest.

Sincerely,

JOHN A. D. COOPER, M.D.

Appendix 3

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND ENCLOSURES FROM DR. EMIL LENTCHNER, EXECUTIVE DIRECTOR, ELEVENTH DISTRICT DENTAL SOCIETY, JAMAICA, N.Y.; TO SENATOR FRANK E. MOSS, DATED AUGUST 31, 1976

DEAR SENATOR MOSS: On returning from vacation, I find your letter requesting information additional to that which I submitted in my earlier response of June 28, 1976.

With reference to questions two, three and four of your inquiry of June 7, 1976:

Question #2—The Dental Society is not empowered to discipline a dental medicaid provider. The Dental Society does have an agreement with the New York City Health Department to review on request the quality of dental care performed by a dentist and to render its judgment to the Health Department as to whether the dental care examined is adequate or inadequate. (Enclosed: agreement reaffirmed July 16, 1976; initiated September 1970). In all cases where submission is made to the Dental Society for such "peer review" the Dental Society submits a complete report of its findings to "Medicaid" and to the dentist in question. Final decisions as to actions which may invoke discipline of suspension or disqualification are solely the prerogative of "Medicaid". The Dental Society has a well structured peer review committee which will provide review only upon request. *Since 1970*, when the enclosed agreement was first arrived at, there have been *only two cases* referred to the peer review committee of the Eleventh District Dental Society for investigation, despite our continuing offer of cooperation in the resolution of alleged inadequate or incompetent performance by dental medicaid providers.

Question #3—As previously stated the Society is not empowered to invoke discipline in medicaid cases. The Society does not have subpoena power, nor is it an agency of government. Hearings relative to medicaid abuse are legally the responsibility of the Departments of Health and of Social Service and of the Office of Professional Conduct which is an agency responsible to the State Attorney General and the New York State Board of Regents.

Question #4—The enclosed peer review agreement is currently in force, but is not utilized to any significant degree by the Department of Health.

I hope this answers your request for additional information. I continue to urge that amendments to federal medicaid legislation will be directed to provide the medically indigent with adequate health care, administered in such a fashion as would encourage participation by the majority of dentists in New York City and State as well as the country. My former letter details the urgent need for reform of the medicaid program.

Sincerely,

EMIL LENTCHNER, D.D.S.

[Enclosures.]

THE CITY OF NEW YORK DEPARTMENT OF HEALTH,
BUREAU OF HEALTH CARE SERVICES.
New York, N.Y., July 16, 1976.

DR. EMIL LENTCHNER,
Executive Director, Eleventh District Dental Society,
Jamaica, N.Y.

DEAR DR. LENTCHNER: The New York City Health Department acknowledges that the following constitutes the terms of the peer review agreement that it has negotiated with the three District Dental Societies of New York City:

1. A peer review committee would be established by each District Dental Society.

2. The district peer review committee would exercise its function in connection with society members, or non-members within its geographic area.

3. The names of the members of each committee and any changes in composition would be communicated to "Medicaid".

4. The peer review committee would concern itself solely with the quality of dental care, and pronounce its judgment as to whether dental care examined is adequate or inadequate.

5. The peer review committee would be convoked by the Dental Society at the request of "Medicaid" whose examinations had disclosed serious or consistent deficiencies, and informal discussions with aberrant dentists had not produced the prescribed improvement in quality of care.

6. The peer review committees shall establish their own internal mechanisms and provide the facilities and equipment for such examinations.

7. After examining patients and records and interviewing the practitioner, the peer review committee will submit a complete report of its findings to "Medicaid" and to the dentist in question.

8. The peer review committee must render its report on a case within 60 days of its receipt from "Medicaid".

9. Although the identity of the dentist in question will be made known to the society, the society will have the option of maintaining his anonymity to the peer review committee up to the time he appears for its interview. A non-member should not be identified as such to the committee.

10. Upon receipt of the report "Medicaid" will take the report of the Peer Review Committee into consideration in making a final decision as to appropriate subsequent administrative actions which may include demands for restitution, suspension or disqualification.

11. The report of the peer review committee findings will always be offered in evidence to hearing officers in formal proceedings.

12. The peer review function represents the commitment of organized dentistry to fostering the dental health of the community and reflects dentistry's responsibility. It offers its service to these ends without compensation.

Sincerely yours,

MARTIN A. PARIS, M.D., M.P.H.,
Executive Medical Director, Medicaid.
ESTHER KAPLAN COLCHAMIRO, D.M.D., M.P.H.,
Director, Dental Medicaid.

THE CITY OF NEW YORK DEPARTMENT OF HEALTH,
BUREAU OF HEALTH CARE SERVICES.
New York, N.Y., September 9, 1970.

DR. ROBERT FISHER,
Chairman, Inter District Committee,
Brooklyn, N.Y.

DEAR DR. FISHER: The New York City Health Department acknowledges that the following constitutes the terms of the peer review agreement that it has negotiated with the three District Dental Societies of New York City:

1. A peer review committee would be established by each District Dental Society.

2. The district peer review committee would exercise its function in connection with society members, or non members within its geographic area.

3. The names of the members of each committee and any changes in composition would be communicated to "Medicaid".

4. The peer review committee would concern itself solely with the quality of dental care, and pronounce its judgment as to whether dental care examined is adequate or inadequate.

5. The peer review committee would be convoked by the Dental Society at the request of "Medicaid" whose examinations had disclosed serious or consistent deficiencies, and informal hearings with aberrant dentists had not produced the prescribed improvement in quality of care.

6. "Medicaid" will be responsible for delivering the patients and their treatment records, evaluation forms and x-rays to the respective societies for examination and evaluation.

7. The peer review committees shall establish their own internal mechanisms and provide the facilities and equipment for such examinations.

8. After examining patients and records and interviewing the practitioner, the peer review committee will submit a complete report of its findings to "Medicaid" and to the dentist in question.

9. The peer review committee must render its report on a case within 60 days of its receipt from "Medicaid".

10. "Medicaid" will make patients and treatment records available to peer review committees in actions initiated by practitioners when the quality of their work has been questioned by Medicaid.

11. Although the identity of the dentist in question will be made known to the society, the society will have the option of maintaining his anonymity to the peer review committee up to the time he appears for its interview. A non member should not be identified as such to the committee.

12. Upon receipt of the report "Medicaid" will, at its discretion, temporarily suspend the practitioner from all participation in the program and set the date for formal hearings by the Department of Health.

13. The report of the peer review committee findings will always be offered in evidence to hearing officers in formal proceedings.

14. The peer review function represents the commitment of organized dentistry to fostering the dental health of the community and reflects dentistry's responsibility. It offers its service to these ends without compensation.

Sincerely yours,

MORTON A. FISHER, D.D.S., M.P.H.,
Deputy Executive Director, Medicaid.

ITEM 2. LETTER AND ENCLOSURES FROM DR. MARTIN MARKOWITZ, PAST PRESIDENT, MEDICAL SOCIETY OF KINGS COUNTY AND THE ACADEMY OF MEDICINE OF BROOKLYN (N.Y.), INC.; TO SENATOR FRANK E. MOSS, DATED SEPTEMBER 9, 1976

DEAR SENATOR MOSS: I am enclosing copies of correspondence dating back to September 15, 1975 which are self-explanatory.

You can see that the Medical Society of the County of Kings alerted officials about Medicaid Mills and requested an investigation of Medicaid practices in 1975.

Sincerely,

MARTIN MARKOWITZ, M.D.

[Enclosures.]

STATE OF NEW YORK DEPARTMENT OF HEALTH,
NEW YORK CITY OFFICE,
New York, N.Y., January 16, 1976.

MARTIN MARKOWITZ, M.D.,
President, Medical Society of the County of Kings,
Brooklyn, N.Y.

DEAR DR. MARKOWITZ: Our New York City Office of Professional Medical Conduct received your letter several months ago that was forwarded to Mr. Robert Asher of the Division of Professional Conduct, New York State Department of Education, and which concerns Dr. Reiter's article entitled, "Medicaid and Me: Condition Normal."

I have recently had a lengthy discussion with Dr. Reiter concerning that article and I referred to your letter dated September 15, 1975. Dr. Reiter told me that his article was a composite of many facilities which can be referred to as "medicaid mills" or "shared health facilities." Dr. Reiter feels that what is happening in these facilities is "parallel to what is going on in nursing homes." He also stated to me that his "beef is with the system, not with any particular physician." He refers to the owners and operators of medicaid mills and shared health facilities as business entrepreneurs.

I am sure Dr. Reiter would be most pleased to speak with you if you wish to discuss this article with him at any great length. His telephone number is 861–5498. We hope we have been of some help to you in your inquiry about the facts behind this article. Thank you very much for referring this matter to our

Office. Please do not hesitate to call on us if there is anything within our jurisdiction that we can investigate for you.

Sincerely,

MAXINE M. ODENWALD,
Office of Professional Medical Conduct.

THE CITY OF NEW YORK DEPARTMENT OF HEALTH,
BUREAU OF HEALTH CARE SERVICES,
New York, N.Y., September 30, 1975.

Dr. MARTIN MARKOWITZ,
President, Medical Society of the County of Kings,
Brooklyn, N.Y.

DEAR DR. MARKOWITZ: I am responding to your letter of September 18, 1975 regarding the article entitled "Medicaid and Me, Condition Normal" by Dr. B. P. Reiter. We have spoken with Dr. Reiter and he tells us his article was a composite of many Shared Health Facilities plus a multitude of tales from his colleagues. He was loathe to name any one place. However, for your information we have an ongoing investigation and indepth audits of many like facilities and we are making concerted efforts to remedy the situation.

As you know Item 230 which would give us some administrative teeth is in the courts. We trust that if this law becomes applicable, we can count on your cooperation in erasing, as you say "blatant unethical conduct by some physicians", thereby upgrading the standards of good medical practice.

Sincerely yours,

JOHN T. GENTRY, M.D., M.P.H.,
Executive Medical Director, Medicaid.

MEDICAL SOCIETY OF THE COUNTY OF KINGS AND
THE ACADEMY OF MEDICINE OF BROOKLYN, INC.,
Brooklyn, N.Y., September 15, 1975.

Mr. ROBERT S. ASHER,
Director, Division of Professional Conduct, New York State Department of Education, New York, N.Y.

DEAR MR. ASHER: I would like to call to your attention an article written by B. R. Reiter, M.D., entitled "Medicaid and Me: Condition Normal" that appeared in the July 21, 1975 issue of New York magazine. I am enclosing a xeroxed copy of the article. If true, this article blatantly reveals unethical conduct by some physicians in the County of Kings.

The Medical Society feels obligated to follow this matter through and investigate the activities of the physicians involved. We enlist your aid in obtaining the names of these physicians so that we may pursue the matter.

Sincerely,

MARTIN MARKOWITZ, M.D.
President.

SEPTEMBER 18, 1975.

Dr. JOHN T. GENTRY,
Executive Medical Director, Medicaid, Department of Health, New York, N.Y.

DEAR DOCTOR GENTRY: I refer you to a copy of my September 15th letter addressed to Dr. Robert S. Asher, Director of the Professional Conduct Division of the New York State Department of Education, regarding an article entitled "Medicaid and Me: Condition Normal" that appeared in the July 21, 1975 issue of New York magazine. In case it went astray, I am enclosing another copy of the article.

Unquestionably, this article reveals blatant unethical conduct by some physicians and very questionable standards of good medical practice.

I should like to know whether your office has investigated this medical establishment and its members. If so, what has been the disposition of this case?

If by some oversight, an investigation has not been conducted, we believe it is

necessary. The Kings County Medical Society has a stake in assuring that good medicine is practiced in our Borough.

I would appreciate hearing from you.

Sincerely,

MARTIN MARKOWITZ, M.D.
President.

ITEM 3. LETTER AND ENCLOSURE FROM SIDNEY G. SPARROW, ATTORNEY, KEW GARDENS, N.Y.; TO SENATOR FRANK E. MOSS, DATED OCTOBER 13, 1976

DEAR SENATOR MOSS: On August 31st my clients, Doctors Joseph Ingber and Sheldon Styles, appeared before your Committee and testified. Thereafter, you forwarded to me a transcript of the hearing minutes and I have returned same under separate cover.

After considerable discussion, my clients have prepared the enclosed set of proposals to your Committee and I forward them herewith in the hope that they may be of some value to you—recognizing as I do that there is good likelihood that most—if not all—of the content has already been assessed and evaluated by you.

Thanking you once more for the opportunity to be of some assistance, I am

Respectfully,

SIDNEY G. SPARROW.

[Enclosures.]

PROPOSALS TO THE SENATE COMMITTEE INVESTIGATING MEDICAID FRAUD

SUBMITTED BY SIDNEY G. SPARROW, ESQ., ON BEHALF OF DOCTORS INGBER AND STYLES

I. WEAKNESSES IN MEDICAID PROGRAM

1. In concept, the program is doctor oriented, rather than patient oriented. It rewards doctors for making more visits rather than fewer visits. Our experience is that this creates many so-called "grey areas" of doctor judgment that can never successfully be challenged.

(a) Was this test necessary?

(b) Was that follow-up exam necessary?

(c) Was that specialist really in for the patient's benefit, or was it for the doctor's increased billing and the Center's increased income?

(d) Are those blood tests being run for income or patient need?

(e) Are unnecessary drugs, shoes (orthopedic), supports, etc. being prescribed?

2. The common abuses this concept of health care fosters are:

(a) Pingponging; every doctor in the clinic sees the patient.

(b) Family ganging; every child is billed for multiple services.

(c) Up-grading; follow-up visits and billed as a first visit.

(d) File picking; names are picked from files at random, leading to totally false invoices.

(e) Overbilling; false visits or extra unnecessary visits.

(f) Round-robin; one doctor after another bills the same patient for services not given.

3. Medicaid Program leads to various incentives to cheat. Amongst them are the following:

(a) Percentage arrangements between doctors, laboratories and factors. Clinic owners as well are allowed to factor through doctors.

(b) Selective justice in the investigatory system (infrequent and spot checking).

II. SPECIFIC RECOMMENDATIONS AS TO PROBLEMS AND THEIR SOLUTIONS

1. *Problem.*—Patients are unsure of where to complaint.

Solution.—The use of a complaint number in a bright color (red) on the Medicaid Card.

2. *Problem.*—There is patient apathy toward doctors cheating.

Solution.—"BountyHunting"—the patient gets a ten percent reward or something similar of all monies recovered from cheating doctors. Similar to methods used by the IRS to informers.

3. *Problem.*—Doctors are rewarded for writing extra visits.

Solution.—(Major) capitation a la H.I.P. Centers where doctors are paid a salary based on the number of people in the area using the facility. A useful concept here would be—"a front line medicine pay" e.g. very good salaries to induce good men to come aboard.

4. *Problem.*—The system of family ganging and ping ponging.

Solution.—Computer profiling with "abuse triggers" to follow up investigation.

5. *Problem.*—Passing around of Medicaid cards in order to get free drugs and care.

Solution.—Picture of the patient on the Medicaid Card.

6. *Problem.*—The doctor billing for services not rendered.

Solution.—Patient signs each invoice.

7. *Problem.*—Some areas have too many clinics and/or there may be a legitimate clinic and other clinics must overbill to survive.

Solution.—Capitation—limit and license multi-discipline centers which treat more than twenty-five percent Medicaid patients, e.g., one center per 10,000 persons.

8. *Problem.*—Front desk administration and the clerical staff ping pong effect.

Solution.—Each center must have a city employee at the front desk as a "watch dog". The "watch dog" may be a paramedic, R.N., or a specially trained new unit of City Health Department team (Health Ombudsman).

III. CONCLUSION WITH REGARD TO SPECIFIC PROBLEMS AND THEIR SOLUTIONS

It is my feeling that if doctors could be compensated generously for working in Medicaid Centers, with the cheating incentive removed, then the situation would return to sanity and could result in savings in the hundreds of millions of dollars. This could also result in unnecessary follow-up visits, unnecessary medication, and society would benefit in general.

IV. SUGGESTED IMPLEMENTATION THROUGH THE LEGISLATURE, ETC.

1. Percentage deals outlawed—flat rent only.

2. Factors should be licensed and rates charged.

3. Separate by law: (a) Factoring from the Center ownership; (b) labs from the Center ownership; (c) limitation on ownership of Centers to only one.

4. Set specific licensing standards for Medicaid Centers with regard to health. supply and staff.

○

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